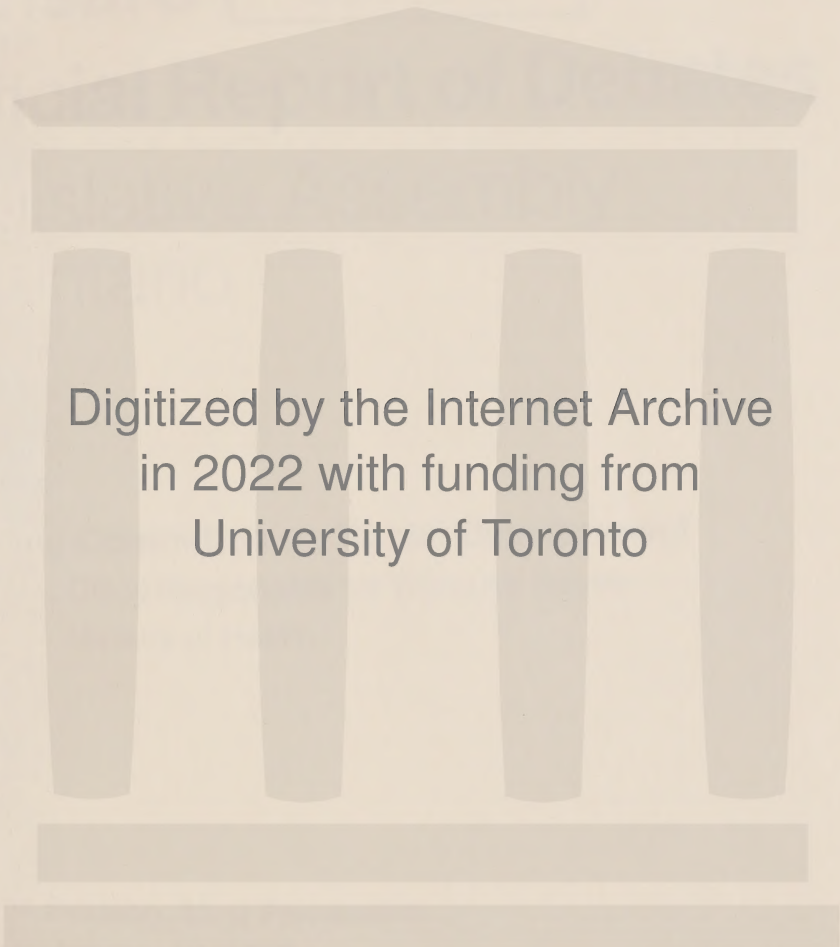

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Official Report of Debates
Legislative Assembly of Ontario

Standing Committee on Social Development

Estimates, Office Responsible for Women's Issues

Estimates, Ministry of Health

Second Session, 33rd Parliament
Monday, January 19, 1987

Speaker: Honourable H. A. Edighoffer
Clerk of the House: C. L. DesRosiers

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday, January 19, 1987

The committee met at 3:26 p.m. in room 1.

ESTIMATES, OFFICE RESPONSIBLE FOR WOMEN'S ISSUES
(continued)

On vote 801, Office Responsible for Women's Issues program:

Mr. Chairman: We reconvene the estimates of the Office Responsible for Women's Issues, vote 801. We have 42 minutes remaining. The minister has a couple of things emanating from the last meeting and then we will go to new questions.

Hon. Mr. Scott: At the last meeting, I was asked by the critics to provide a breakout of the costs of the family violence initiatives that were announced recently. I have those here in appropriate numbers for the committee.

Second, I was asked by you, Mr. Chairman, and by others about the expansion with respect to beds for battered women. I gave you an answer but I have it more thoroughly documented here, and I provide that.

I will be glad to respond to any questions you or members of the committee have to the limit of 41 minutes now.

Mr. Chairman: Or 40 minutes. Who knows? Things move so quickly when we are having fun. I think it is fine just to table these at this point. I know Ms. Gigantes wanted some of this material and I will make sure it is provided to her.

Mr. Jackson, did you have questions?

Mr. Jackson: Yes. I have a couple of questions dealing with the general area of training, certain barriers to training and certain initiatives by the government targeted specifically to women.

I understand the Premier (Mr. Peterson), very early in his tenure, made reference to special programs for women to deal with their unique needs. We assumed that was part of the government's approach to target specific training initiatives in that direction. When the document entitled Ontario's Training Strategy was tabled by your colleague the Minister of Skills Development (Mr. Sorbara), there seemed to be some concern about the very general nature of the document. You have indicated you were monitoring the performance of various ministries and giving them advice and counsel. I am just wondering to what extent you are advising that ministry to specifically target training to women.

Hon. Mr. Scott: As you know, the experience has been that women in the work force do not take up training at a rate that reflects their position in the work force. For example, roughly 44 per cent of the full-time labour force in Ontario is women and roughly 47 per cent of the unemployed work force in Ontario is women. None the less, women represent no more than 33 per cent of the trainees in federally sponsored training programs and no more than 41 per cent of the trainees in federal job creation programs.

This experience in which women take up less than their proportionate share of training programs is not characteristic only of federal programs and seems to be a result of the fact that women are unable to make the kind of link with employers that male workers make, particularly in the nontraditional occupations. There are also other reasons.

The minister's programs are designed to reduce the prospect that this experience will be duplicated in those programs. We have spent considerable time with him and his staff with respect to the Ontario skills program and the access to training programs in an effort to ensure that the risk will be minimized.

Mr. Jackson: How are you doing that?

Hon. Mr. Scott: By the setting of goals and by the development of a mechanism, which I was discussing with the minister only this morning, to measure as you go along the extent to which those goals are achieved. Instead of waiting for the end of the program two years down the line to look back and assess whether it worked, you can monitor the program from week to week and month to month and make the necessary adjustments.

The minister has responded to this goal-setting exercise in connection with his programs with respect to youth unemployment, which is a major phenomenon, and within that program and within his other programs with respect to native employment and visible minority employment. What we hope the minister will do and what we have been encouraging him to do and understand

he is doing is establishing goals and monitoring compliance with those goals.

I can tell you this morning, for example, we were looking at the question of whether the goals in the Futures program and in these programs for native young people had been met. He was able to produce figures that showed what the uptake of those programs was. The issue is always whether the goals are the right goals. Second, when you have the uptake, how do you modify the program so it will be more creative? Quite often we have found it is a simple question of communication with the constituency you want to attract.

Mr. Jackson: I think the record of the last 18 months with respect to targeting for women has not been as good as we had hoped. We could discuss several specific programs; for example, the Open Doors program, which is a linkage with our school boards. In my capacity as Skills Development critic, I discovered to my sheer horror that the minister was not engaging in dialogue with school boards with respect to the success of this program. Therefore, we are not surprised to see that participation levels have dropped.

Hon. Mr. Scott: Are you referring to the Open Doors program?

Mr. Jackson: The Open Doors program, just as one example.

Hon. Mr. Scott: The Open Doors program is not run by the minister; it is run by the Ontario women's directorate.

Mr. Jackson: Then I am talking to the right person, am I not?

Hon. Mr. Scott: Yes, but the Open Doors program is not a program in the Skills Development cluster.

Mr. Jackson: But it reinforces the work of the ministry.

Hon. Mr. Scott: Yes, but–

Mr. Jackson: Let me move to a second project. When the minister made his announcement concerning Ontario's Training Strategy, he made only four comments with respect to targeting women specifically. He said, "training services are targeted to the service sector where most women work"–that sounds somewhat logical–"and where many women require training to move out of occupational 'ghettos.'"

Could you please explain why you would be devoting more energy to that than you would to the training needs of young people, given–and this is why I am bringing in the conflict with the Futures program–that over 70 per cent of the applications in certain of our help centres are from women who are over the age of 25 and therefore ineligible for the program?

Hon. Mr. Scott: I do not understand the difficulty to which you are trying to direct me.

Mr. Jackson: I have asked you a question about how you are monitoring and you have said that all you have asked the minister to do is to set goals so that you can measure whether he is reaching his target groups. I am asking you what specific programs you are encouraging the minister to develop instead of monitoring the general program of Futures, which many have agreed is not working to meet the specific needs of women?

Hon. Mr. Scott: Have you asked him this question?

Mr. Jackson: Yes. I got a terrible answer.

Hon. Mr. Scott: What does he say about it? Before you call it terrible, what does he say about it?

Mr. Jackson: He confirms that he has had no major dialogue between the various participants, the secondary school systems throughout Ontario, the community colleges and the women's directorate.

Hon. Mr. Scott: Let me put to you what I think we are doing in this area at present and what it means. We are encouraging the minister, with considerable success in so far as he develops either training or job creation programs, to target–we do not speak in terms of quotas, but target–or set goals for various groups of disadvantaged people in the employment marketplace. Those groups run all the way from women to minority women, minority citizens, the handicapped and native people. We say, "Set targets and we will participate with you, as will other ministries, in setting realistic targets."

Setting targets is not enough. You have to set up a mechanism so that you can assess fairly quickly where you are in meeting those targets. Then, if you fail to meet the targets one month, you can move in very quickly and make an adjustment in the scheme that is designed to bring you up to target. That is the position the women's directorate and some other directorates have taken with the minister. We have had from him excellent support in that exercise. From time to time there will be discussion–there always is–about whether the goal or the target is right, whether the reporting mechanism is frequent enough or whether the adjustment you make to meet the target is right. But he is on side and doing that exercise.

We in the women's directorate run some programs, such as the one you discussed, which are designed to encourage women and girls to move into nontraditional occupations. Open Doors is an example of that program, which is designed to take nontraditional models before girl students in the school system and say, "Here are some of the things you can do if you make the following course selections now."

Last year I went out to a couple of schools. It is quite fascinating when you have a panel of five women and the girls in the class ask them questions such as, "What do you do?" It turns out that one of them is the foreman of a construction job and earns $48,000 a year; and you go on down the line. Girls in the classes find there are nontraditional occupations open to them and they begin to ask, "What do I have to do to get that kind of job?" It usually turns out that what you have to do is you have to begin taking math and science in grade 9.

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Mr. Jackson: What are you doing with respect to the public school system to reinforce that? We have talked with guidance counsellors. There have been a couple of pilot studies in Toronto where they have had incredible success with all-girl math classes and the measurement of that. There is also a study that was done just recently by the Halton Board of Education. That should be forwarded to your directorate. If the board has not thought to send it to you, I am sure I will–

Hon. Mr. Scott: The basic reality is that you cannot get a whole lot of women into a whole lot of nontraditional jobs if you cannot get them to take math and science in grade 9 and carry on with it; that is the sine qua non. More nontraditional jobs are closed off on account of that failure than, I am sure, any other single factor; so your focus has to be there. Some six or eight months ago, you heard the Minister of Education (Mr. Conway) announce a major science program designed to do exactly that: to get not only girls but also everybody into science in a big way, because we are finding that not only are girls foreclosed from nontraditional occupations but boys as well.

Mr. Jackson: Have you seen the dollars that are earmarked for that program in his estimates?

Hon. Mr. Scott: I have not been to his estimates.

Mr. Jackson: No; they are about to occur. As you know, Ontario's Training Strategy is a very generic program; it embraces all of the previously targeted programs. One of those programs–

Hon. Mr. Scott: We know that is why you like it so much, because some of the programs are your own.

Mr. Jackson: It is easier to sell to the public when you can market one major project rather than target the individual. It has worked very effectively in terms of public polling; the Liberals are perceived to have done something because there is so much of it, they keep reinforcing Futures. But I am pleased to see you have at least acknowledged the need to measure these programs, because that is where the effectiveness really will occur.

During those estimates, I asked the Minister of Skills Development the extent of his measurements and I was amazed to learn of the limited amount of measurement that was going on. At least we are getting it–

Hon. Mr. Scott: I think he is not doing badly on that score. I talked to him this morning and–

Mr. Jackson: He could not tell us, for example, the number of students who opted out of the program at the various stages and the numbers of returnees–something as basic as that.

Hon. Mr. Scott: I think it is much more important than that.

Mr. Jackson: However, he has been given about $750,000 just for computers and another $500,000 for additional personnel; so I am sure he will be a wonderful number-cruncher.

The women in skills, trades and technology, which was specifically designed for a given purpose, which we are talking about, was rolled into Ontario skills. When I asked the minister whether he intended to eliminate the project or whether he would continue with it, he used the phrase "winding down and incorporating it." In other words, he would not be phasing it out completely but would be changing the emphasis. The current commitments of the existing program would be honoured, but after that it would be part of his whole new approach. That is basically what the minister said to us in estimates.

Are you happy about that or are you satisfied? Have you been given privity to what he is going to replace it with?

Hon. Mr. Scott: First of all, the Ontario women's directorate provides an advocacy function. Our function is to see–

Mr. Jackson: Yes, I remember that from the first day of estimates. I understand that clearly.

What are you advocating with respect to this question?

Hon. Mr. Scott: I cannot tell you that, because cabinet solidarity does not permit me to describe the discussions I have with ministers. However, I will tell you that I am much–

Mr. Jackson: You just told me about a conversation you had with the minister earlier this morning. Was that inside or outside of cabinet?

Hon. Mr. Scott: I forget right now where it was. I had better be careful. I do not want to–

Mr. Jackson: Given that you want to advise the minister, what do you think your directorate should be advising the government in that respect?

Hon. Mr. Scott: I think the directorate is concerned to assure that in so far as possible, training programs and educational programs designed to open up nontraditional occupations for women are well structured. That means having a goal-setting function and having a capacity to report as to whether the goals have been met.

Our function generally, I think, will be to see that the programs have as a design requirement that women are to benefit either generally or specifically from the program; we look to that type of mechanism. If a minister has those in his program and they work, we say great. If he does not, I do not tell you about it but I talk about it.

Mr. Jackson: One of the barriers the minister identified was the barrier of day care. I was absent for one of the sessions with respect to these estimates and this matter may have been covered, so I will beg a short answer. Was the issue raised of moving the child eligibility age from the current age level of 10 to, say, 13 because of the particular problems associated with supervision for 11-, 12- and 13-year-olds?

Hon. Mr. Scott: I am not certain. I would be happy to inquire into whether that precise issue was raised.

Mr. Jackson: It would have been raised in your presence here. I am asking whether it came up.

Hon. Mr. Scott: No. It has not been raised here.

Mr. Jackson: Then I am raising it. Since that has clearly been regarded as a barrier within a barrier–access to day care is a barrier but there is this further barrier of the age bracket–has there been any advice from your advisory council to any ministry with respect to moving that age qualification bracket?

Hon. Mr. Scott: I cannot tell you what the advice has been; I can tell you, for what it is worth, one of the good things about Ontario's Training Strategy is that it does have a support allowance program, which is there precisely for, among other things, the provision of child care services for women who take advantage of the program. That is the sort of thing the women's directorate would be very supportive of. What you are telling me, if I understand it, is that you think the cutoff for child care is too low under that program.

Mr. Jackson: It has been identified by many of the women clients in the help centres. In the Futures program, with its threshold of age 25, there is such an over-emphasis on youth unemployment that we are missing that group of older worker–that is a terrible statement to make–aged 26 and above. That is a barrier within the program because we are not allocating as many dollars to those individuals and they generally have children in that age bracket.

Hon. Mr. Scott: All I am telling you is the OTS program has a support feature, as I understand it, that permits the provision of child care. If you are telling me the child care cutoff is too low and I should take that up with the minister, I will be delighted to discuss it with him for you.

Mr. Jackson: You will get back to us on that?

Hon. Mr. Scott: I will tell you when I have discussed it with him.

Mr. Jackson: You will be out of cabinet then.

Hon. Mr. Scott: You will have to deal with him in estimates on whether the program he selects and cabinet approves meets your expectations.

Mr. Jackson: Given that you are the advocate, I was hoping to deal with you and hoping you would see the wisdom of this, embrace it and proceed to–

Hon. Mr. Scott: Having heard what you say, I intend to take up my advocacy.

Mr. Jackson: It is much appreciated. I will pass.

Mr. Chairman: You have had a salutary effect on the minister, and we appreciate it.

Because we go only until 4:08 p.m., I want to get some idea how many members wish to participate, so we make sure we give everybody a chance. Mr. Shymko has indicated he is interested in putting some questions to the minister. Is

there anybody else? If not, perhaps you two can resolve time-splitting between you.

Mr. Jackson: I will yield to the member.

Mr. Shymko: Thank you. I will try to focus my remarks and question the minister as long as I can on an issue I know he is very sensitive to; that is the whole area of inequity in the salaries of women.

Approximately two months ago, while the Attorney General and the Premier were absent, I raised a question in the House with the acting Minister of Government Services (Mr. Conway) on some of the serious discrepancies in the area of not just pay equity or work of similar value but also of equal work performed by women who are employed by the provincial government and who are doing essentially the same work. Many of them are Portuguese immigrant women.

The cleaner who cleans my office in the Whitney Block, who is described as a heavy-duty cleaner–

Hon. Mr. Scott: Which would often be the case.

Mr. Shymko: We can make fun of this, Minister, but I think it is a serious matter and I do not think you should.

Hon. Mr. Scott: Forgive me.

1550

Mr. Shymko: He is paid $6.26 an hour. A similar individual cleaning my colleague's office in the Legislative Building is paid $10.01–a difference of $3.75.

I would imagine that heavy-duty cleaners would probably be males; I do not know, but it is something that I would like to know, the difference here being, as I say, $3.75. Light-duty cleaners–I assume the majority would be women–are paid $9.01 in the Legislative Building and $5 in the Whitney Block–a difference of $4.01–for doing the same work. In other words, the difference between the male-oriented heavy category of cleaners and the light cleaners, the majority of whom are women, is even higher in terms of the discrepancy of salary: $3.75 for heavy and $4.01 for light.

They are doing the same work. The difference here, apparently, is that the cleaners working in the Legislative Building are classified staff while those in the Whitney Block–two per floor, six floors, approximately 12 people–as well as the Frost Building North and South–another 12; a total of about 24; close to the figure of the cleaners involved in the Canadian Union of Public Employees issue–are all unclassified and nonunionized.

Hon. Mr. Scott: Who are they employed by?

Mr. Shymko: This is information I have received from people such as Yvonne Gregson, assistant to Roger Muller, manager of legislative services at the Ministry of Government Services. They are employed by a company called Active Carpet Cleaning. It is a Canadian company, it is nonunionized and the contract expires January 13, 1987, so it has probably expired already and I do not know whether that contract has been renewed.

In the Frost Building North and South–same people, same salaries–the company is Concord Building Maintenance Ltd., which is not a Canadian firm. It is a US firm, again contracted out. The contract apparently was just renewed recently–that information came to me in October or early November of last year–for two years.

In that discrepancy between classified and contracted out, I understand that contracting out has been a policy that was not established by your government. It may have been established in the past. I do not know what differences existed in 1977-78 when the changes in contracting out came into effect. I do not know.

However, as the years go by, the increases that you see are in the classified area–believe me, the increases in the unclassified, nonunionized area are minimal–so the difference from 1986-87 may be quite different from the differences of classified/unclassified, unionized/nonunionized 10 years ago. I do not know. I think it is something that you, Minister, should look into, whether or not we move in a direction of a greater discrepancy year after year. These are the two extremes.

There is a third category of cleaners who clean the rest of the buildings in the Queen's Park complex, which includes the Macdonald Block and all the other area. They are apparently hired, contracted out again, and they are working for Concord Building Maintenance Ltd., once again a US firm. I have no idea of the numbers there. I would like to know. I have not received an answer and I have waited for one for the past two and one half months.

All of them are unclassified, but they are unionized. I assume their salary would be somewhere in between the classified and the unclassified nonunionized workers. It is a concern to me.

I believe in your sincerity in pay equity and in trying to rectify that terrible injustice. However, right under our noses, we have employers who perpetuate that inequity of equal work, never mind similar work or similar value, but equal

work with a difference of $4. If you multiply that per week, it is quite a difference in take-home pay.

These are immigrant women. I am sure we all speak very eloquently, including the Minister of Citizenship and Culture (Ms. Munro), on the concerns we have for immigrant women and we try not to allow their exploitation–

Hon. Mr. Scott: It is not a problem only for immigrant women, you know.

Mr. Shymko: In this case, for some peculiar reason–

Hon. Mr. Scott: I can give you examples.

Mr. Shymko: I am talking about us here.

Hon. Mr. Scott: I can give you examples of highly qualified, sophisticated computer operators in the government service who are paid X dollars and who are paid more than computer operators in the private sector to whom the government contracts work. You would make precisely the same case: that the highly trained and highly skilled computer operators in the private sector are paid less than the computer operators who are direct employees of government. You would be making exactly the same case. It is a case that has to be addressed.

The point I make about it is that it is not really a pay equity issue in any traditional terms. It is a contracting-out issue. The issue always becomes whether a business, be it a government or a private sector business, has the right to contract its services to the private sector or to some other business if the result is that the rates of pay will be lower in the second business.

The third party has taken a very clear position on this issue, which is basically to restrict to a very severe degree the number of cases in which contracting out is permitted. They will be delighted to have your support on this question.

Mr. Shymko: The salary involved in contracting out to a high-tech firm by the Ministry of Government Services is quite a different salary than that involved in contracting out these types of jobs in which the majority are people who are susceptible to exploitation in our society. They are immigrants. They are women who will take any job at any price.

We are speaking about inequities and pay equity while equal work is being done here and we are not addressing this. Are you aware of that and what are you doing about it?

Hon. Mr. Scott: I am aware of it. I want to make the point that it is not a point that turns around minority women, although the example you give is one involving minority women. It involves a lot of contracting out.

The second point is that it is not peculiar to government. Contracting out, whether you approve of it or not, is a phenomenon that Ontario business has adopted to a very significant degree.

The same group of women who are no doubt cleaning those quarters over there, cleaned the office building in which I worked for years until their jobs were contracted out. I did something. I went on the picket line with them, but I was complaining about the contracting out of the jobs. That is the real problem here.

Mr. Shymko: If you are telling me I should not be talking to you but I should be talking to the owner of Active Carpet Cleaning, I think you are wrong.

Hon. Mr. Scott: No. I am saying it is possible for government to structure the contracts it lets to the private sector by saying to the persons with whom it contracts, "You will not be allowed to pay a salary lower than we in government pay."

Mr. Shymko: Hear, hear.

Hon. Mr. Scott: That has never been done.

Mr. Shymko: Are you planning to do this?

Hon. Mr. Scott: I do not think we are planning to do that.

Mr. Shymko: Are you planning to review the contracting-out policy so that the inequity is eliminated?

Hon. Mr. Scott: I will take it up with the acting Minister of Government Services. You were talking to the right minister.

1600

Mr. Shymko: I know I was, but I am talking to the conscience of this government. I am talking to the individual who represents the conscience and the–

Hon. Mr. Scott: The competitor for that title has just arrived.

Mr. Chairman: He is pointing to some obscure man in the front row.

Mr. Shymko: We are talking about a policy for which you are the advocate and the guru.

Hon. Mr. Scott: The problem of contracting out is not a women's problem alone. It is a problem that affects any person whose job is contracted out or who is among the class of people who are doing the work that is contracted out. It happens to men as well as to women.

The so-called evil to which you address yourself has nothing to do with equal pay; it has everything to do with whether the contracting out of services should be permitted and, if so, on

what terms. That is why I draw to your attention that the computer operators, whose jobs are contracted out and displaced, are in precisely the same difficulty as the group you describe. Governments and legislatures have to make a decision about whether contracting out is going to be permitted and, if so, on what terms.

The answer of this government has always been that if it is in the public interest for the efficient running of government to let contracts to the private sector, we will do so. What we will require the private sector to do is to comply with all the laws that its competitors in the private sector have to comply with.

Even in Bill 154 you will see that affirmative action, which is to impose a special rule that applies to nobody else on someone who wants to deal with government is not a route we have selected. Why? Because it means that in the private sector someone has to do something special to contract with this government. We do not think that is right. We think everybody should have to comply with the same rules.

Mr. Shymko: Are you saying you are happy if the owner of Active Carpet Cleaning and Concord Building Maintenance, a US firm, provides a salary for these nonunionized cleaners that is the same as in the private sector?

Hon. Mr. Scott: I am not happy with it because I would like to see everybody, including legislators, paid at the top rate.

What I am saying is that if you want to resolve this problem, the solution is to try to persuade the Minister of Labour (Mr. Wrye) and the government that contracting out, wherever it occurs, in whatever business, should be restrained or permitted only on defined terms, as the third party proposes.

That is the issue. It is not an issue that has anything to do with women per se, although undoubtedly it is an issue that affects a large number of them.

Mr. Shymko: In the light of the $400 million the Treasurer (Mr. Nixon) found by some chance in his coffers, we should rectify this position and make them all classified.

Hon. Mr. Scott: They do not work for the government. Their employer would be astounded to find them classified.

Mr. Shymko: Why do we not at least make sure they are paid at the rate set by the Ministry of Labour? I understand they are being paid at the Ministry of Labour rate for nonunionized workers.

In other words, what that owner is paying is not illegal but the discrepancy is there, particularly the hypocrisy we are trying to rectify. We contract out under a policy that has this discrepancy and the difference, the gap, increases every year.

I am glad to hear you will be speaking to the acting Minister of Government Services. I would appreciate if you could use your clout.

Hon. Mr. Scott: No, I said you should speak to him.

Mr. Shymko: I did. For two and a half months, I have not had an answer. This is why I am in this committee speaking to you, as the conscience of the Peterson government and as the individual who is so eloquently providing the leadership in this area, to speak to the minister.

Hon. Mr. Scott: I was just going to make a policy announcement but I think I can contain myself.

Mr. Shymko: I still have a few minutes left. Is there a policy to hire American firms versus Canadian firms?

Hon. Mr. Scott: What do you mean by an American firm?

Mr. Shymko: Concord Building Maintenance, for example. Are there not Canadian companies that would be preferable?

Hon. Mr. Scott: Why do you think it is an American firm; because it is called Concord? It could be Concord, Ontario.

Mr. Shymko: It is an American firm. It is US-based.

Hon. Mr. Scott: Do you mean its owners are American people?

Mr. Shymko: Yes, they are.

Hon. Mr. Scott: If Americans are permitted under our laws to invest their capital in Ontario, if they come here and do that and if they comply with the rules the Legislature and the Parliament pass for doing business in the province, I do not think we should discriminate against them. Some people go so far as to think we should discriminate against out-of-province providers of services and goods. I do not think we should do that.

Mr. Shymko: To give credit to Concord, it has allowed for the unionization of most of its cleaners; at least the vast majority are unionized.

Hon. Mr. Scott: It is not that Concord has allowed for the unionization of its members; it is that the law you helped to pass—I presume you were there on the day—permits those employees certain rights. The employees have taken advan-

tage of those rights, and what their employer thinks of it has nothing whatever to do with it.

Mr. Shymko: Have you thought about why those working for Active Carpet Cleaning are not initiating unionization procedures or forming a union?

Hon. Mr. Scott: There are one or two reasons, perhaps three: (1) they do not want to be represented by a union; (2) they are unaware of the advantages union representation will bring them; or (3) they are frightened for their jobs, which occasionally happens.

Mr. Shymko: Do you know why they are frightened for their jobs? I know why and will tell you why. The government of Ontario is employing illegal immigrants. That is why. Is it not the policy of the government to investigate or make sure individual private companies to whom we contract out do not exploit illegal immigrants? Should we not be doing that?

I am afraid to raise this issue because the minute we start doing it, these ladies will lose their jobs. They will be fired. We should probably take a look, to be very careful we are not accused of hiring illegal immigrants, because some of them may be illegal immigrants.

Hon. Mr. Scott: You are saying that some of the companies with which the government has contracted have hired illegal immigrants?

Mr. Shymko: May have hired. I have a suspicion that may be the case.

Hon. Mr. Scott: All I can suggest to you is that if you think an offence has been committed under the law, you should provide the information you have—and I know you will—to my ministry, and we will inquire and see whether the law has been broken.

Mr. Shymko: If you discover that some of them are illegals, will you fire these people?

Hon. Mr. Scott: I cannot fire them; they do not work for me. If you are suggesting that a company has broken the law or that you think it may have broken the law, the appropriate course is to provide the information you have to either me or a crown law officer so an investigation can be conducted.

Mr. Shymko: All I am saying is we should look into that area. I beg you to look into these problems with these women to make sure.

Hon. Mr. Scott: Will you be good enough to write to me so I can provide all the information you have to the crown law officers of my ministry?

Mr. Shymko: You just told me I should be writing to the acting Minister of Government Services.

Mr. Chairman: I sense that for the protection of these people involved, it may be wise if we use up the next 30 seconds in taking a vote.

Mr. Shymko: Thank you.

Mr. Chairman: It is not the corporations that get punished for this sort of thing.

Mr. Shymko: Absolutely, they do not.

Mr. Chairman: That is why raising it does not do a damned bit of good for the workers. Not to get involved in this, and since we have now used up the time of the committee, may I ask members whether it is their will that vote 801 carry?

Vote 801 agreed to.

Mr. Chairman: This completes consideration of the estimates of the Office Responsible for Women's Issues.

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ESTIMATES, MINISTRY OF HEALTH (continued)

Mr. Chairman: We now move to the Ministry of Health and that man hiding in the front seat, Mr. Elston.

I call the committee to order. All the records from the Ministry of Health are being wheeled in at this point.

Hon. Mr. Elston: This is last week's material.

Mr. Chairman: It is the response to questions put by certain members.

Mr. Andrewes: This is actually the briefing material for the committee we are waiting for now.

Hon. Mr. Elston: We have been told that stuff is with you guys. I do not think we need to have too many jokes about it. If it is not there, you had better tell me for sure.

Mr. Chairman: Everything has been filed with the clerk. Members such as me have not seen it as yet.

Maybe I will bring to people's attention at this point that there has been a change. The select committee on health was supposed to start meeting tomorrow. Obviously, having the Health estimates scheduled for the same time would have caused some conflict. The select committee is now scheduled to meet Wednesday and Thursday afternoons of this week. Tomorrow we will continue with the Ministry of Health estimates.

It has been a little while since we were together. May I presume at this stage that Mr. Andrewes has the floor? Would that be appropriate, or do you have something specific to respond to?

Hon. Mr. Elston: I was not exactly sure. I was just going to ask somebody. Dr. Wasylenki arranged to be here today, seeing that this was to have been his day to perform. Since the weather is in such abominable shape, it would be inappropriate to send that gentleman home without addressing the issue.

Mr. Chairman: I had forgotten about that.

Hon. Mr. Elston: Dr. Wasylenki on electroconvulsive therapy. I presume he will be available shortly.

Mr. Andrewes: My colleague has one very brief issue that he wishes to raise.

Mr. Chairman: If it is all right with you, Mr. McCague, we will start off, take an individual issue and then leave it to me to make sure we have enough time for the doctor. We may have to cut you off at some point, or we may get a chance to deal with it entirely. Is that all right?

Mr. McCague: Great. The minister could answer this positively and it would be all over.

Mr. Chairman: It would be a matter of seconds. He looks as if he is in a very positive mood today, so anything is possible.

Mr. McCague: Minister, I believe you have had correspondence and requests to license one nursing home bed in Stayner. You have others where they probably licensed 10 or so when they originally built their building. With regard to the licensing of 50 beds in Stayner, it was made clear to the lady who owns the nursing home that she would get only 48 beds licensed and that she had to have one emergency bed on top of that. She would not get that one bed funded.

The problem for you, and certainly for me as the MPP, is that as long as that one bed is there, people continually keep harping back to why we do not fund it, without knowing that they were told initially it would not be funded. I would be glad to have an answer from you today as to your intentions in that regard. I would be very happy if you said, "Yes, I will do it." I have put all this down in a letter for you.

Hon. Mr. Elston: I recognize the nature of your argument. I am actively pursuing the question of the Stayner nursing home bed. You have made the commonsense argument, and it has been put to me as well by the owners there. I am sympathetically reviewing it to see whether anything is possible. I am not prepared to make an announcement today, but it should not be long.

Mr. McCague: I did not think you would. I hope, because of something of which you may or may not be aware that happened in my riding in the not-too-distant past regarding announcements, if you are going to announce this, I will at least know at the same time as the people of Dufferin-Simcoe.

Hon. Mr. Elston: I will make sure.

Mr. Chairman: Is there anything else? Thank you, Mr. McCague. I appreciate that.

At this point, let me move on to what was anticipated for today. I will ask Dr. Wasylenki to come forward to the area directly in front of me and have a seat.

I had sent a message—I know Mr. Reville has an interest in this, and I asked the clerk to go and try to contact him. You say he is in—

Mr. Andrewes: He is in the House doing the Housing estimates, unfortunately.

Mr. Chairman: He will not be able to come from that, I am afraid.

As the minister said, I am not sure what we can do in terms of scheduling, especially given the weather. Where do you work, Doctor?

Dr. Wasylenki: Whitby.

Hon. Mr. Elston: The difficulty was that we had changed the presentation from when it was originally supposed to occur. Once we were unable to have the doctor's presentation on the day Mr. Reville was here, we were going to try to make it available for him rather than for us because we are in a situation—even if it were tomorrow, for instance, Mr. Reville will probably still be in the Housing estimates, as I understand it.

Mr. Chairman: I think they are moving legislation tomorrow; they were as of this morning. You are right that you can never tell. We might as well proceed at this point.

Hon. Mr. Elston: I think we should deal with it. In any event, I am quite prepared to speak to Mr. Reville directly and, if need be, we can set up a more satisfactory day when we might be able to go down to Whitby. In fact, at one time or another, I have tried to look at what might be possible in arranging to take critics or others to view some of our programs. That may be possible at another time, but for today, if we can just go through this maybe we can handle many of the questions.

Mr. Chairman: Why do we not do that today and ask the doctor to make his presentation. We

will try to make it available to Mr. Reville as quickly as we can, so that if he does have questions for you perhaps he can put them to you tomorrow.

Dr. Wasylenki: Thank you. It is a pleasure to be here and to be able to present this material to you. The way I thought I would approach this is to give you a bit of background information on electroconvulsive therapy, and then to take you through the recommendations our committee has made. First, I will give you the background information.

To start, I will give you the definition of electroconvulsive therapy. It is a medical procedure that consists of the electrical induction of a generalized convulsion, under general anaesthesia, for the treatment of certain mental disorders. Essentially, it is the electrical induction of a seizure. It has been used in psychiatry since about 1938, so we have nearly 50 years of experience with this treatment modality.

Let me explain what it is not, because there tends to be and has been some confusion. First, electroconvulsive therapy is not the administration of a burst of electrical stimuli for behaviour modification. Remember, this is the issue of the use of so-called cattle prods in institutions for the developmentally handicapped. In fact, there was some confusion about these two issues in the Globe and Mail some time ago. That is not ECT.

It is not a subconvulsive electrical stimulation of the brain that is used in what is called narcotherapy or sleep therapy, where people receive very low energy stimulation, a technique that has a somewhat shaky scientific foundation. That is not ECT. It is not a surgical procedure. It is not invasive. No tissue is removed and no changes or lesions in the brain are produced as a result of electroconvulsive therapy. That is what it is not.

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Now, what do we use it for? The condition for which we use ECT most frequently is severe depression. When I talk about depression, I am not simply referring to feelings of sadness or disappointment. There is a medical syndrome, a constellation of signs and symptoms in psychiatry which constitutes what is called major depressive disorder. This is the principal indication for electroconvulsive therapy.

The condition consists of intense feelings of despair, along with feelings of worthlessness, feelings of hopelessness, often delusions, that is, fixed false beliefs about what is going on around the patient. There are a number of physiological symptoms, including loss of appetite, often very significant weight loss, 30-40 pounds in a period of months, a lot of agitation, decreased energy and, almost always, suicidal ideation. That is the condition that ECT is most commonly used to treat.

Since the early 1960s, we have had drugs to treat major depressive disorder, so-called antidepressant medication. The approach to most people with severe depressive disorder is, first of all, to attempt to treat the disorder with antidepressant medication, and that is successful in about 70 per cent of cases. For the remaining 30 per cent of severely depressed patients, the only alternative treatment that we have is ECT and it is effective in about 80 per cent of that 30 per cent of cases.

The commonest indication for the use of this treatment modality is severe depressive disorder that does not respond to antidepressant medication, and the success rate is very good. I do not know what we would do with this patient population if we did not have this modality. There are some other reasons why we may tend to use ECT in this condition. The response to it is much more rapid than the response to drug treatment. Even patients who do respond to antidepressant medication take two to three weeks to respond to the medication.

If there is a significant degree of urgency, if the patient, for example, has made a serious lethal suicide attempt and is likely to do so again, we might consider ECT before a trial of medication; or if inanition and dehydration are significant concerns, as they often are in elderly depressed patients, in order to keep the person alive once he has stopped eating and stopped taking fluids, we might consider ECT first; or if there are medical contra-indications to the use of antidepressant medication which has significant side-effects, primarily involving the cardiovascular system.

It is somewhat paradoxical, given the perception of electroconvulsive therapy, but it is a safer form of treatment than tricyclic medications for many patients. For elderly patients who have pre-existing heart disease, for pregnant women to whom we always hesitate to administer any medication, for those kinds of patients, ECT is a safer form of treatment for severe depression.

Those are the kinds of situations where we might consider using ECT without a trial of antidepressant medication. In the usual situation, the treatment approach is first to try drugs and, if the drugs do not work, then to think about electroconvulsive therapy.

The other condition that ECT is sometimes used for is schizophrenia. Patients with schizophrenia present, with hallucinations, with delusions, often with incoherent speech in the acute phase. By and large, we treat schizophrenia with antipsychotic medication and various kinds of psychosocial therapies. There are some relatively rare instances where the acute phase is so disruptive and difficult to control with medication that we may use ECT to achieve some degree of behavioural stabilization. This is extremely rare now.

In the past—and I am talking about in the 1940s and 1950s when we did not have antipsychotic medications—ECT was used frequently for schizophrenia. It is not clear whether it has any real impact on the course of schizophrenia, and schizophrenia is a relatively rare indication for the use of ECT now. The predominant indication is for depression.

Let me describe the procedure briefly so that you have a sense of what is involved. When a physician feels that ECT is indicated, the first thing that happens is that he fully informs the patient about the nature of the treatment, the risks and the benefits and attempts to obtain informed consent. If the patient is competent, informed consent is obtained and the procedure is then instituted. If the patient is incompetent, then the same discussion occurs with the relative or appropriate next of kin.

One of the problems in this whole area of consent is that many of the symptoms of those mental disorders for which ECT may be prescribed affect markedly the competence of the patient. It becomes a very difficult area at times. The Clark report, for instance, reaches some interesting conclusions about how the issue of competence should be dealt with if we are going to restrict the availability of this treatment modality to competent patients.

Once consent has been achieved, a series of medical investigations is carried out to be sure there is no medical contra-indication for the treatment. The treatment consists, first of all, of the patient being given a drug called thiopental, which is a barbiturate anaesthetic that puts the patient to sleep.

The first thing that happens in the treatment room is that the patient is put to sleep. The patient is then given a drug called succinylcholine, which is a muscle relaxant, so that the patient's muscles are relaxed. Once that relaxation has occurred, the patient is given 100 per cent oxygen and assisted ventilation. Then the electrodes are placed over the patient's nondominant hemisphere—that is, the cerebral hemisphere that does not contain the majority of memory and verbal functioning. Then the treatment is administered. A seizure is induced, but because the patient's muscles are relaxed by the succinylcholine, an actual seizure does not take place. There is a minimal degree of muscle contraction, which allows us to observe whether a generalized convulsion has been induced. This lasts about 60 seconds.

Following that, the patient is taken from the treatment room to the recovery room. A nurse usually stays with the patient for about half an hour until recovery is achieved and the patient can go back to the ward.

ECT is also done on an outpatient basis. When this occurs, we always advise and arrange for somebody to be with the patient for at least three to four hours after the treatment.

The frequency of treatment in hospital is usually three times a week, and a normal course of electroconvulsive therapy is about eight treatments. In about 80 per cent of cases the outcome is very successful.

The mechanism of action—how inducing a convulsion results in significant improvement with depression—is unknown to us, as is the cause of major depressive disorders. There is some suggestion, predominantly from animal research, that the mechanism of action of antipsychotic drugs, which involves making nerve cells more permeable to certain chemicals that elevate mood, is the same mechanism as in electroconvulsive therapy, but the permeability is more massive and immediate. There is a kind of flooding of the nerve cells with this chemical neurotransmitter. That is still a hypothesis.

We have a very effective form of treatment, but we do not understand exactly how it works. The use of electroconvulsive therapy is based on empirical and clinical results.

What about the side-effects? The major issue with this treatment is memory loss. There are three different ways of thinking about this. First of all, nearly all patients who have this treatment experience some degree of memory loss for events around the treatment period; that is, for a few weeks before and a few weeks after. This type of memory loss clears spontaneously about six months after a course of treatments. It is temporary, transient and of no lasting effect.

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In a small number of patients—and we do not know how many—there is some degree of permanent memory loss as a result of this treatment. It is patchy, it is not a global memory

loss, but there may be loss of specific memories that may be permanent for events occurring usually in the time just before the course of treatments.

There is no good longitudinal study demonstrating this, but there are anecdotal case reports illustrating it. Part of the difficulty is that when people become severely depressed, they complain of subjective memory impairment. Their thought processes slow down as part of the illness and there is a subjective experience of difficulty remembering and concentrating. This makes it difficult to untangle whether there is objective memory loss, in what proportion of patients and whether it is a symptom of the depressive disorder. It underlines one of the important recommendations in the Clark committee report and in our deliberations: that is, the need for more research into these matters.

There is no diminution in the capacity to remember in patients who have had electroconvulsive therapy. In other words, some memories may have been lost by some patients, but the capacity to form new memories after a course of treatment is unaffected.

Those are the three dimensions of the memory issue: the transient loss of memories around the treatment period that occurs in many patients and that returns after about six months; a patchy memory loss that occurs and that may not return in a small proportion of patients; and the fact that the ability to remember, the memory capacity, is not affected.

The other side-effects tend to be somewhat miscellaneous and not overly problematic: transient headaches, some confusion–I am talking about effects that occur in the immediate post-treatment period that tend to clear quite spontaneously. We no longer see the musculoskeletal injuries that used to occur when patients were not anaesthetized and did not receive muscle relaxants before the treatment and an actual grand mal seizure was induced. People fractured vertebrae and had other difficulties. There are transient changes in blood pressure; it goes up a bit during the treatment. The heart rate may increase and there may be changes in cardiac rhythm. Again, these are very transient, occur during the treatment and are not lethal.

There is no evidence of any permanent structural brain damage in humans following electroconvulsive therapy if it is given with an anaesthetic and a muscle relaxant. In the early literature, some changes were reported from autopsies that were subsequently found to be due to lack of proper oxygenation during the procedure. If you give laboratory animals massive amounts of electroconvulsive therapy or shock their central nervous system 100 to 1,000 times beyond what would be considered for human patients, you may be able to produce some scarring of the central nervous system. These results have not been accepted as being applicable to electroconvulsive therapy in human subjects.

As most of you probably know, a recent review in the Ontario Supreme Court concluded, after reviewing all this evidence, that ECT does not cause permanent structural brain damage, and that is the finding of the profession.

The mortality rate for this form of treatment is four to five per 100,000 treatments. That is lower than the mortality rate for inpatient dental surgery. There have been 22,000 treatments administered at the Clarke Institute of Psychiatry since its opening, and there have been no fatalities. What is really important to understand is that the mortality rate for severe depressive disorders is 551 per 100,000. People with severe depressive disorders commit suicide at a very high rate, and elderly people with these disorders often die of malnutrition dehydration. We are dealing with a potentially lethal condition in a way that is relatively safe and highly effective.

There are few absolute contra-indications to this treatment modality. One is increased intercranial pressure. Anything that causes pressure within the central nervous system to be increased is a contra-indication to electroconvulsive therapy because of the increase in blood pressure that occurs during a treatment. This means basically that people with brain tumours should not receive electroconvulsive therapy.

The other absolute contra-indications are threatened retinal detachment, for the same reason–that increasing pressure on the central nervous system may precipitate a detachment–and patients with very unstable vertebral columns on account, perhaps, of severe rheumatoid arthritis. Those are the three absolute contra-indications now.

Relative contra-indications, where we are looking at risk-and-benefit kinds of issues, include recent miocardial infarction, because there are some changes in heart rate with the treatment; aortic or cerebral aneurysms, conditions which may be worsened by rises in blood pressure; recent intracerebral haemorrhages and the use of a particular type of medication, monoamine oxidase inhibitor, which themselves may cause hypertensive crises. These are the kinds of things we are ruling out when we do the

medical work-up in preparation for electroconvulsive therapy.

The last issue I want to comment on before moving to our committee work is the issue of the concern about ECT, because it is a safe and effective treatment modality that we need for those drug-resistant patients who are severely ill, but there is a lot of opposition to it.

I think the concern is based in a number of areas. First, there is the early history of electroconvulsive therapy. When ECT was first discovered in the late 1930s and began to be used in the 1940s and 1950s, there were no other treatments for the major mental disorders. We did not have antipsychotic medication for schizophrenia and we did not have antidepressant drugs, so ECT was used relatively indiscriminately. Everyone was given a trial of electroconvulsive therapy because nobody really knew what it was good for and there was nothing else. I think there are still people around who lived through, and were patients during, this era who have very legitimate concerns about how this modality was used.

Second is the appearance of the procedure. As I mentioned, up until the early 1960s no anaesthetic was used, no oxygen was applied and no muscle relaxant was available, so a person was brought into a treatment room, given a shock and had a grand mal seizure. It was a terrible thing to witness. It is still the only procedure in psychiatry that requires a general anaesthetic. I think these are issues in people's ability to look rationally at the procedure.

The concern about side-effects is a valid concern. We need to do more investigation, and the fact is that we do not yet understand the mechanism by which ECT works. All these contribute to the concern about the continuing use of this treatment modality.

To give you a brief sense of the frequency with which we use ECT in the Ontario hospital system, our hospital has 413 beds, and we treat, on the average, two to three patients per month with electroconvulsive therapy. There tends to be a little more of it used in general hospital psychiatric units because they tend to be dealing with more acutely ill patients, but within our own Ontario hospital system, that is pretty close to the frequency throughout.

In our experience in the past year, 80 per cent of patients who received ECT gave their consent for the treatment, and in the other 20 per cent of cases we obtained consent from relatives. We did not have to go the route of going to a review board in any cases in the past year. That is the route that has been available if a competent patient refuses ECT and the physician seeks a treatment order. That is done very infrequently.

Mr. Andrewes: I missed the first figure on the frequency.

Dr. Wasylenki: In the past year, at our hospital, it has been two to three patients per month.

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Mr. Andrewes: That is in Whitby?

Dr. Wasylenki: Yes. I recently looked at the figures for the most recent nine-month period for five hospitals in the province for which we have data, and there were no cases that have gone to the review board for treatment orders for those five hospitals. This is background.

Concerning how I got involved in this: as you know, back in December 1983 a decision of one of the provincial review boards to authorize a course of ECT for a competent involuntary patient was appealed in a district court. The court found that the review board was within its jurisdiction to authorize the treatment. As a result, press reports and the Ontario Coalition to Stop Electroshock brought all the controversy surrounding ECT to the attention of the public.

In February 1984 the former Minister of Health, Keith Norton, appointed Charles J. Clark QC. to head an interdisciplinary review of electroconvulsive therapy in Ontario. Their report was tabled in the Legislature in December 1985. After that, I was asked by the mental health area to convene a committee within the mental health area involving representatives from the Ontario hospitals to look at the issue of operationalizing recommendations of this report within the Ontario hospital system. The pivotal recommendation in the report was that ECT continue to be available in Ontario, with extensive safeguards based on sound legal, ethical and medical principles. It was really the issue of those safeguards to which our committee addressed itself.

The committee consisted of the medical directors from five of the Ontario hospitals, two of the chief executive officers of Ontario hospitals and two psychiatrists from the department of psychiatry at the University of Toronto. We spent a lot of time on this. We met six times between February and October 1986. We submitted our report in October 1986. I was present at a meeting with representatives of the Ontario Medical Association, the Ontario Psychiatric Association, the Ontario Hospital Association, the Association of General Hospital Psychiatric

Services and the Ministry of Community and Social Services to discuss this report further. The meeting was convened by Mr. Corder. The report was then reviewed by all the medical advisory committees within the Ontario hospitals and is now in the process of being implemented.

I am not going to go through the report in detail. I would like to explain the four major sections of our report. The first section consists of a set of medical staff guidelines for the use of electroconvulsive therapy. These address issues such as the type of information with which patients need to be provided, the nature of the consent that has to be obtained, the nature of recording in the clinical record, the need for ongoing dialogue and assessment of the patient's competency, the need for a second opinion in certain situations and comments about guidelines regarding who should be administering ECT in various clinical settings.

We also included a guideline with regard to the issue of patients wishing to revoke consent, explaining that in some situations normal anxiety results in concerns about continuing treatment, but that in other situations physicians must carefully assess and respond to a patient's desire to discontinue a course of treatment.

That was the first part of our set of recommendations: that is, the guidelines that we have proposed be incorporated into policies and procedures in the 10 Ontario hospitals.

The second part of our recommendations addresses standards for electroconvulsive therapy equipment. There is in Canada a standard developed by the Canadian Standards Association that refers to equipment safety, which is applicable to electroconvulsive therapy equipment. What we lack in Canada are performance standards for ECT equipment, standards that address issues such as how much energy an ECT machine should be able to deliver, the duration of current, etc. We have recommended that the Canadian Standards Association, in consultation with the Canadian Medical and Biological Engineering Society, develop performance standards for electroconvulsive therapy equipment to be used in Ontario, and that subsequently all electroconvulsive therapy equipment be examined by a qualified biomedical engineer to ensure that those performance standards are being achieved and that equipment that does not meet the safety and performance standards is withdrawn. The process of developing those performance standards is under way.

The third section of our report addresses what both we and the Clark Electro-convulsive Therapy Review Committee think is an important issue, the collection of standardized information on electroconvulsive therapy in the 10 Ontario hospitals. We have suggested an approach to recording that would ensure the same data is recorded for each individual treatment and each course of treatments in each hospital. We would be able to look at patterns throughout the province and identify issues that arise with the use of this treatment modality. This is a format that has been developed and used at the Clarke Institute of Psychiatry and has been piloted in two of our Ontario hospitals. It now has been accepted by the medical advisory committees of the other eight hospitals.

In the final component of our report, we brought to the attention of the ministry some examples of the type of written educational material we think should be made available to patients to whom electroconvulsive therapy is being recommended. It outlines in very straightforward fashion exactly what the treatment consists of, what the procedure is like and the pros and cons. This information is being reworked to make it clearer for our patients because the stuff we could find is a bit jargonish.

Most of the recommendations of our committee are in various stages of implementation. They have been generally well accepted by the medical advisory committees in our hospitals and are being looked at very carefully by the psychiatric units in general hospitals throughout the province with a view towards applying them there as well.

Hon. Mr. Elston: For the purposes of the record, now that we have had all the background information, perhaps the doctor can identify himself and his position so that we have it in Hansard.

Mr. Chairman: That is the sort of thing any good chairman would have asked.

Hon. Mr. Elston: Sorry about that.

Mr. Chairman: Silly devil.

Hon. Mr. Elston: I did not want it to pass at this point.

Dr. Wasylenki: My name is Donald Wasylenki. I am the psychiatrist-in-chief and clinical director at Whitby Psychiatric Hospital.

Mr. Chairman: Thank you. As one of the people who is irrationally opposed to the use of what I call abhorrent behaviour on behalf of psychiatrists in the province, perhaps I can ask you a few questions that seem to have been fuzzed over in what you have put forward. How strong is the electric shock? Describe the electric shock more thoroughly for us.

Dr. Wasylenki: It is difficult to describe because it depends on the type of machine that is used and the shape of the wave form that is administered. The machine most commonly used in the province today delivers a sine wave type of current. The amount of energy is usually in the area of about 100–

Mr. Pierce: Amps?

Dr. Wasylenki: No, it is the current measure. I am talking about the energy level; hertz of energy.

Mr. Chairman: That is a good word, is it not? There are different machines. What is the range of these machines around Ontario in terms of their output?

Mr. Pierce: Hertz is the voltage.

Dr. Wasylenki: Hertz is the measure. It is the amount of energy the machine is allowed to produce. The problem is that resistances and other parameters vary so you are never sure exactly how much energy is being administered. The issue with regard to equipment that needs to be clarified is whether the newer machines that deliver pulses of energy are superior to those delivering a single current of energy. There are basically two types of machines, machines that deliver a fairly continuous amount of energy and machines that deliver pulses of energy. The literature suggests that the pulsatile wave form is probably desirable because you can produce a convulsion with less total energy. In fact, most hospitals replacing equipment are replacing it with machines that deliver pulsatile energy. The performance standards that are developed will likely recommend this.

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However, some more recent literature suggests that sometimes, with these newer machines, convulsions do not occur with the lower amount of pulsatile energy and that more pulsatile energy is being administered. The desirability of the newer type of machine over the older type is not quite as clear-cut as it appeared to be even six months ago. That is why the performance standards need to be developed.

Mr. Chairman: I always find it amazing that in the history of electroshock therapy we started off using something we did not know would work and that we still have no idea why it works. I am not going to spend time asking questions about what success is, given that some of my friends who were successes are no longer with us. I find it strange that we are administering this stuff but still have not worked out such things as standards for the amount of energy that should be applied. In terms of medical ethics, I find that incredible. Can you explain a little more the physiology of a convulsion and what happens when this electricity goes through somebody's head?

Dr. Wasylenki: First, I want to make it clear that electroconvulsive therapy machines are carefully calibrated and are allowed to deliver energy within only a very narrow range. There are performance standards for these machines in various jurisdictions. Most of the machines are manufactured in the United States. The American Psychiatric Association has performance standards that it recommends and that are enforced. Performance standards have not been developed in this country and it is our feeling they should be. The machines are produced in conjunction with performance standards that do exist. It is not as if any manufacturer can produce a machine in any way he wants to.

Mr. Chairman: How were they developed? Can you give us a history of how these standards were developed in the United States? Were they based on trial and error and watching what happened? Is that not what it was?

Dr. Wasylenki: It was based on clinical trials.

There was a second part to your question, what happens when a convulsion occurs. Part of the central nervous system, the reticular activating system which is deep beneath the cerebral cortex, is activated by the electricity that is produced. A generalized state of hyperexcitation of the central nervous system occurs so that neurons discharge spontaneously throughout the central nervous system. Chemicals are released when neurons discharge and it is felt that some of the chemicals are neurotransmitter substances that are depleted in people who develop severe depressive disorders. It is a kind of flooding of the central nervous system with neurotransmitters that tend to produce a state of euphoria and elation.

This is the same thing we think antidepressant drugs do, only they do it much more slowly. That is why it takes two to three weeks for those drugs to start working. You have to build up the levels of these neurotransmitters. It is thought to be basically the same process, but with electroconvulsive therapy the process happens much more quickly and probably in a more concentrated fashion.

Mr. Chairman: Are there any jurisdictions in the industrialized world that do not use electroconvulsive therapy?

Dr. Wasylenki: None that I am aware of. As you probably know, in Berkeley–I am not sure whether that is a municipality–electroconvulsive

therapy was banned several years ago. It has since been restored. That is the only jurisdiction I am aware of where the treatment modality was disallowed for any length of time.

Mr. Chairman: Is it allowed all through western Europe and North America? How many kids, people under the age of 18, were zapped last year?

Dr. Wasylenki: None that I am aware of. It is very rare that electroconvulsive therapy is prescribed for anyone under the age of 18.

Mr. Chairman: The Clarke Institute of Psychiatry has done them before. I know because I raised it two years ago.

Dr. Wasylenki: I was talking to a very experienced child psychiatrist at our hospital. She could remember only one case in the province for a person under the age of 16 during the time of her experience. The only situation where it would be imaginable to use electroconvulsive therapy on someone under the age of 16 would be in a very rare condition that is called juvenile onset manic depressive psychosis where a young child may develop the same severe depressive syndrome we see in adults. This would be done only after very extensive consultation within child psychiatry. It would be a very unusual occurrence, certainly in Ontario.

Mr. Chairman: The figure I remember from a few years ago was six, that they may have been 16 to 18 years of age.

Dr. Wasylenki: Perhaps closer to 18. Whether you would even consider it has to do with the maturity of the central nervous system. There are some 18-year-olds who are physiologically and developmentally very adult and who develop major adult mental disorders.

Mr. Chairman: What is the oldest age range you are administering it to in Whitby?

Dr. Wasylenki: We administer electroconvulsive therapy when there are good indications for it to psycho-geriatric patients, patients over the age of 65. There would be no upper age limit. One of the points I want to emphasize is that for many elderly people, this is a much safer treatment for severe depression than antidepressant medications. Many people who are older and who are depressed have pre-existing cardiovascular problems and the antidepressant drugs cause cardiac arrhythmias and hypotension as a major side-effect. When you are dealing with someone in his 70s who is severely depressed, who has stopped eating and drinking and who is essentially mute—I am thinking about a case not long ago, brought in from a shack in northern Ontario—it is sometimes much safer to think about electroconvulsive therapy than about antidepressant medication. There is no upper limit to the age range.

Mr. Chairman: An 80-year-old in Ontario may receive this therapy for depression?

Dr. Wasylenki: Yes.

Mr. Andrewes: You mentioned that the general hospitals that have psychiatric units were considering guidelines. As a general guideline, are you convinced that psychiatric units in general hospitals should be using ECT?

Dr. Wasylenki: Yes, I am; certainly.

Mr. Andrewes: What sort of support can you give to that?

Dr. Wasylenki: The same support I suggested earlier. Seven out of every ten severely depressed psychiatric patients can be treated with antidepressant medication. That leaves us with three out of every ten who do not respond. The question then becomes, "How do we approach those patients?" There is nothing else we can do for them. Often, when the depression becomes severe and after a period of attempted treatment with antidepressant medications, the patient is essentially unresponsive and electroconvulsive therapy becomes the only treatment modality we have left.

There are some people who feel that undertreatment of major depressive disorders may be the number one public health problem we are faced with in North America. There are many, many severely depressed people who do not receive any form of treatment. There are many severely depressed people who do not receive electroconvulsive therapy when they could benefit from it because of some of the fears we talked about. To me, that is the support for the use of ECT in general hospital psychiatric units.

Mr. Andrewes: I am looking at a number of Clark's recommendations. The first two, three or four deal with second opinions on ECT procedures. I have not seen your report, but I assume some of those suggestions are incorporated when you talk about medical staff guidelines.

Dr. Wasylenki: Yes.

Mr. Andrewes: Is the staff available in a psychiatric unit of a general hospital to satisfy that kind of support requirement?

Dr. Wasylenki: In most areas of Ontario now, it would not be difficult to obtain a second opinion on a patient for any reason in psychiatry. It is conceivable that a situation could arise somewhere in the province where it might be

very difficult, but certainly not impossible. In the vast majority of psychiatric units in general hospitals it would be very easy to obtain a second opinion.

1700

Mr. Andrewes: Can you expand a little on the committee's recommendation on the procedures for consent?

Dr. Wasylenki: First, we have basically said that the consent, to be informed, has to satisfy current Canadian standards for disclosure with regard to the risks and benefits of any medical treatment, and we have outlined our understanding of the current Canadian standard. Therefore, the first issue is that the consent must be fully informed. Second, the consent must be free. There cannot be any coercive influence. We said that there needs to be a specific consent form for electroconvulsive therapy in each hospital, and that consent form has to include information about the upper range of the number of treatments for which the patient is consenting. It must also inform the patient that he has a right to revoke consent at any time during the course of treatment.

Mr. Andrewes: What about the question of risks, side-effects, degree or duration of improvement or remission, treatment alternatives and associated benefits?

Dr. Wasylenki: All those are in our guidelines. We have listed all those things as issues that must be discussed with the patient by a physician. The information about those things is also included in the written material we suggest patients be provided with.

Mr. Andrewes: A good deal of this Clark report deals with the issue of competence. Can you expand a little on how the committee feels about his recommendations on competence?

Dr. Wasylenki: Yes. We did not agree with the recommendation in the report that would disallow a physician from going to a regional review board and obtaining a treatment order for a severely depressed patient who is competent in refusing ECT. We feel we should still have that avenue because we do not know what to do with that patient if we are not allowed to administer ECT. Here is a case in point. Several months ago an elderly lady was severely depressed and refused to eat and drink and was wasting away in front of us. She understood what shock treatments were and refused them. Therefore, under a very narrow definition of competence, she was competent. She had given up hope and wanted to die.

Given the recommendations of the Clark commission, we did not want to pursue the option we had, which was to go to a review board and get a treatment order, which we had done in the past. This lady knew ECT worked very effectively with her. She was eventually admitted to a general hospital where she became delirious as her medical condition deteriorated. At that point, she could be seen as incompetent. ECT was administered with the consent of her son and she improved dramatically.

If we have to go this route with these patients every time, it seems to me we are not doing a service to anyone. Using a very narrow definition of competence, you are handcuffing us in dealing with these kinds of patients if you take away our ability to go to a review board and say: "This lady is very sick. She will not consent. We know ECT has helped her in the past. We understand her refusal to consent is very much a part of her depressive state. She feels she wants to die, so why would she consent to the treatment? We would like permission to treat her." If we cannot do that, we have to wait until people are almost dead in some of these situations before they become incompetent and we can proceed.

The way the Clark commission tries to get around this a little is by saying: "Maybe our sense of what competence means has been a little too narrow if we are going to say that if you are competent and you refuse, that is absolute. Maybe we have to have a more liberal definition of what is competence and what is incompetence." They suggest, for example, that patients who are unable to express a subtle choice about treatment should perhaps be seen as incompetent.

Perhaps a patient whose decision is based on a single fixed delusion—this is the most problematic situation for us, a patient who understands what treatment is but refuses to accept it because he believes the hospital staff are attempting to poison him; that person would be seen as competent, using a narrow definition.

The Clark commission is suggesting maybe those patients should be seen as incompetent in such situations, in which case the consent passes to the guardian or a relative. If the concept of competence or incompetence is expanded a bit, we could treat some of these very difficult cases. If it remains quite limited and the review board option of getting a treatment order disappears, we are going to have problems with these patients.

The other recommendation of the Clark commission, which I think no one has taken very

seriously, was that those patients could be sent off to some facility we would develop that would be especially for severely ill, competent people who did not want to be treated. That seems a very regressive solution to most of us.

It is a very complicated issue. I believe the Mental Health Act allows us to look at competence and incompetence in a somewhat broader way. Not only does it have the concept of understanding, that is the patient must understand the treatment modality, but also the patient must be able to appreciate the consequences of accepting or not accepting treatment.

Once you introduce the dimension of appreciation, which means the patient has to be able to apply the information to his own condition, you begin to allow consideration about how some of the effects of these illnesses can interfere with competence. If a patient is so depressed that he wants to die, even though he understands what the treatment is can we really say he is competent to make a decision about it? That is the issue we are faced with in this area.

Mr. Andrewes: I understand we are going to have that discussion again on another day.

Hon. Mr. Elston: It is one we always have to go through. It is not only particularly relevant to this situation but it is a question that is relevant to several other areas where people have requested that there not be treatment for any number of physical ailments as well. There is the question of when a government agency must intrude to have treatment delivered to a child, for instance, which we have seen just recently adjudicated upon in the courts, or at least was about to be when some arrangement was arrived at.

The question of people making a decision to refuse treatment when that decision would lead to death, and the whole area of the ethics and morality of trying to deliver as much treatment as possible, is not limited specifically to this area. I saw a program not long ago when I was in Ottawa, a US public broadcasting television program which dealt with the question of delivering intensive treatments to a very small baby. The issues are always how far you go and how far you can go, when are you being overly intrusive and when is the right time to intervene or not intervene.

This issue on the consent side of psychiatry's interventions with people will be brought back to us. I am looking at a draft bill now which can be introduced in the Legislature so we can have a public discussion in committee, where people can come and put that side of the discussion. We can have a very thorough analysis of what we are doing before the amendments to the Mental Health Act go into effect on April 1, 1987, barring amendment.

The way in which I am proposing to do that is to introduce an amendment to the act so we can have our discussion specifically on those items of consent. That issue does not then form part of a much broader-based discussion which probably clouded the deliberations of all the people. We will be able to put that case–I was going to say right here, but I do not want to say which committee it might come to. In any event, we will have those discussions.

With respect to the guidelines, I was just speaking with the deputy a couple of minutes ago. When you advise a patient about the treatment and the side-effects, the benefits and all that, do you do that only at the start of the series of treatments or do you then revisit the discussion each time one of the eight treatments in the series is delivered?

1710

Dr. Wasylenki: We suggested in our guidelines that there needs to be ongoing discussion between the attending physician and the patient about these issues through the whole course of the treatment. It is very important to do that.

Again, it gets back a little bit to the issue of competence, but one of the problems with having competence adjudicated by a review board, which is another new development now, is that competence fluctuates in patients, whether they are being treated or not being treated. In response to this question, it is very important for the physician to be aware of improvements in competence which may occur in the course of treatments or developments in the opposite direction.

That is another reason for insisting on ongoing interaction around all these issues between the attending physician and the patient receiving electroconvulsive therapy.

Hon. Mr. Elston: At some stage in the delivery of the treatments do you involve the family if there is a fluctuation in and out of competence? Do you involve the family members as well so you end up having more or less a community approach, as it were, to the acceptance of or consent to treatment?

Dr. Wasylenki: Fortunately, in modern psychiatry, not too much goes on without the family being involved, in the cases where there is a family. One of the problems with patients in Ontario hospitals is that many of them do not have families any longer or interested relatives. Certainly, when there is a family involved and

available, we work with the family throughout the course of treatment.

If we are proceeding on the consent of a family member and the patient becomes competent in the course of treatments, we immediately shift to obtaining consent from the patient, and the family would be involved in that process.

Hon. Mr. Elston: When I am deliberating upon questions–I was talking about this to the chairman who just left the chair before Dr. Allen came in and to a couple of others–one question that always goes through my mind is, would you, as a family member who is also a psychiatrist, assent to having one of your family go through ECT?

Dr. Wasylenki: Certainly. In fact, I have been in that situation and I did.

Hon. Mr. Elston: In that situation I guess you cannot find a higher endorsement than not only having done it practising, but also endorsing it for a family member.

Dr. Wasylenki: One of the most interesting accounts is a book written by a man named Norman Endler who was a consulting psychologist at Toronto East General Hospital at the time he developed a very severe depressive illness. He talks about his own feelings about agreeing to have this form of treatment, his experience with it and his reflections now. It makes very interesting reading and it is very informative for people grappling with these issues.

Hon. Mr. Elston: The former chairman mentioned the question of success and what success may mean or may not mean. I think he mentioned in his comments that some of his friends who had gone through it were no longer here. Is there any indication at this stage that going through the series of treatments causes other physical ailments, side-effects which could end up in reducing length of life?

Dr. Wasylenki: None at all. I have talked about all the side-effects from ECT that we are aware of. The life expectancy of people with major depressive disorders is not as long as other people because many of them do commit suicide and many of them die from malnutrition and other causes when they are not treated, but there is no indication that electroconvulsive therapy results in a shortened lifespan or anything like that.

Hon. Mr. Elston: We have talked about depression, which is the major problem. What other areas might be susceptible?

Dr. Wasylenki: The issue of schizophrenia. What has happened with ECT and schizophrenia over the years is that progressively we have realized that although it may at times assist behavioural control in people who are clearly out of control and whom we have not been able to handle in other ways, there is really no therapeutic effect on the course of the illness in schizophrenia. That is why the indications for the use of ECT in schizophrenia are now very narrow. It tends to be most successful in patients with schizophrenia who have depressive symptoms along with the illness.

The other condition for which ECT is sometimes used, which I did not mention because it is quite unusual to use ECT for it, is mania, which is the other side of the depressive spectrum in a sense. These are patients who are extremely manic, who run about, have pressure of speech, have flights of ideas, cannot concentrate, who very often get involved in self-destructive activities and who can be extremely difficult to manage.

For the small segment of those patients who do not respond to medication, ECT is sometimes quite effective in getting a handle on the severe episode. However, because the medications for mania, particularly lithium carbonate, are so much better now, we rarely use ECT. It has become almost exclusively a treatment for severe depressive disorders.

Hon. Mr. Elston: Can the person who has gone through ECT become susceptible to chemical therapies after having been introduced to it, or do you find that once a patient has received it, he must continue it?

Dr. Wasylenki: When someone recovers after a course of electroconvulsive therapy, we usually maintain him on antidepressant medication. Because the antidepressant medication is being administered and the patient is being followed carefully, we start to get a feel for when another depressive episode is developing and we can increase the medication.

It is much easier to treat someone with medication at the beginning of an episode of illness. It is like asthma. It does not take much asthma medication at the beginning of an attack but once a full-blown attack has occurred, it is a whole other matter. The same is true of depression.

We are often able to get control with antidepressant medication because we are sensitized to following the patient. We can identify when the depressive episode is starting and increase the medication at that time. It is when we get a full-blown severe depressive disorder

and the patient is not responding to the medication that ECT tends to be the treatment of choice.

Hon. Mr. Elston: Basically, we are seeing this as a continually decreasing therapy in many cases. Even in depression, as drug therapies become better, this subsides in usage.

Would you say that Whitby Psychiatric Hospital is a typical institution from the standpoint of treatment? You mentioned two or three patients a month. Would you think there are about the same number in the others?

Dr. Wasylenki: Yes.

Hon. Mr. Elston: A question that has been raised by the deputy is whether there are patients who request ECT.

Dr. Wasylenki: Yes.

Hon. Mr. Elston: If they do that, they would be competent to do that. They make their choice and they actually request it.

Dr. Wasylenki: Yes. A patient suffering from a severe depression is in a great deal of psychic pain and is experiencing a tremendous amount of despair. Some patients who are unable to accept even the two or three weeks it takes for the antidepressant medication to become effective will ask for electroconvulsive therapy. Two or three weeks of the kind of suffering these people experience is certainly a significant experience for many of them.

The Vice-Chairman: Are those patients who have had it previously?

Dr. Wasylenki: Yes, usually.

Mr. G. I. Miller: You mentioned the case of the older lady whom you could not treat until she got to a certain stage. If the family requested that treatment, could you have given it to her at that point?

Dr. Wasylenki: No. You see, that is the issue. She seemed to be competent, and when a person is competent there is nothing the family can do to force treatment upon that person. Until April 1, 1987, only a regional review board can authorize that treatment. Families are often very confused about this situation and often get very angry about it.

Mr. G. I. Miller: Is that the legislation we are contemplating changing?

Hon. Mr. Elston: The legislation I was talking about introducing, which proposed the amendment to the amendment, is precisely on that point. We can use this forum, a very open and public forum, to discuss the types of items that just came out here. I imagine we would have people from all sides of the question come in and we could deliberate solely on this item.

1720

Mr. G. I. Miller: We have had a few cases, then, with no treatment and yet the husband or the wife had to contend with that.

Hon. Mr. Elston: That will be a more detailed discussion in one of the legislative committee forums. It will help us try to understand exactly what, not only the people affected but also the professionals who are asked to provide the treatment or help are forced to work with. It is an extremely important question that we cannot easily let slide.

The Vice-Chairman: Thank you both very much.

Mr. Pierce, I understand you wish to raise a matter.

Mr. Pierce: Yes, I do. The matters I have to raise are riding-related problems of northern Ontario. I am sure if the minister cannot respond, he would be prepared to respond in writing at a later date.

Hon. Mr. Elston: I am sure I would. This would be a good time to get them on the board. If I can give a quick answer to them, fine. If not, we will take them under advisement and get back to you.

Mr. Pierce: In recent meetings with some of the doctors in northwestern Ontario, serious concern was raised over the fact that there is no rheumatologist west of Thunder Bay or in Thunder Bay. There may be one in Thunder Bay I am not aware of, but I was not able to find this information. The doctors in Fort Frances are very concerned about how to refer patients to rheumatologists when there are none available.

Hon. Mr. Elston: I cannot tell you anything more about the availability, but if there were none, we would pay for the travel of the people either to Winnipeg or to an appropriate centre. Maybe there is one in Sudbury or Sault Ste. Marie; if not, in the southern part of the province. I imagine Dr. Copeman would be interested in that particular professional problem.

Mr. Pierce: The question being raised by the doctors is whether a program could be established where a rheumatologist would be allowed to travel to northwestern Ontario on a fairly regular basis and provide the necessary treatment. Rather than move a lot of patients around, we would prefer to move a doctor into the area.

Hon. Mr. Elston: Yes. Under our northern medical specialist incentive program, we would

encourage that to occur, but we would still have to find a rheumatologist to do the travelling. That is what we would prefer to see.

Our early indications show a change with respect to some specialists establishing in Sudbury, for example, where we were a couple of weeks ago at a cabinet meeting. For instance, the referral pattern for the very small babies, the neonates, born in the new unit in Sudbury has changed. Some of the patients who used to come to Toronto are being seen by the paediatricians and obstetricians manning the new unit in Sudbury. Any time we can encourage that type of activity to occur, we support it. Our program would support the type of travel you indicate. We have not yet found the person, at least as far as I understand from your question.

Mr. Pierce: Is there anything in the program administration that would allow you to contract for a doctor in Manitoba if one is not available in northwest Ontario?

Hon. Mr. Elston: We have a working relationship with the Health Sciences Centre in Manitoba. I presume that would not be very difficult to work out. If I am not mistaken, there are working arrangements between the Manitoba physicians and the Ontario health insurance plan already. I am sure certain arrangements might very well be accommodated. The question always is, though, whether there would be a willingness to travel from Winnipeg up into Fort Frances, Sioux Lookout or wherever that need might be.

Mr. Pierce: The other concern by the doctors present, of course, was about the intended cutbacks in the training programs for doctors through the universities and how it would reflect on the availability of doctors to locate in the north. Any cutback in the number of doctors coming through the universities would reflect on the number of doctors who are prepared to make use of the programs that allow doctors to travel into northern Ontario. There is a major concern that it is going to have dramatic effects on the number of doctors who are available for northern Ontario hospitals.

Hon. Mr. Elston: From what I can tell just in reviewing the data from the number of training positions for doctors to enter into any kind of specialty or to go through their internship, it does not seem to have been directly affecting the availability of physicians to northern communities.

A person might well argue, I suspect, that because you have reduced the number of residencies, perhaps there will not be enough people to move into northern Ontario. However, I can tell you right now, for instance, that anaesthesia was brought to my attention, particularly by one person. We have a very good supply of people providing anaesthesia here in southern Ontario, so that in some cases people on staff at facilities are perhaps not working full weeks, but that has not caused a migration of anaesthetists to northern Ontario.

I do not think the fact that we may be contemplating a reduction in the number of people who will be getting residencies in anaesthesia will have a direct bearing on whether a person is going to move into Elliot Lake, for instance, where there is a problem. The things that really bear very greatly on whether a person moves to another community are whether he is going to be the only person delivering anaesthesia in that community and whether there would be any support for him.

Sometimes it is the working conditions. It is not that the conditions are that bad, but the fact that you are the only person who is going to be there on call seven days a week, 24 hours a day, has a bearing on how you might perceive the stress you would undergo in delivering that service.

I do not think decreasing the number of residencies would have the same impact as that other factor would have with respect to going into a northern community where we already know what support services for specialists, both from a peer person position and otherwise, we would have.

In addition to that, I would indicate that our graduates of foreign medical schools program will add 24 people to pre-internship positions this year, there will be 24 funded internships next year and the following year there will be a total of 48 fully funded internships, which really means there will be an increase in the numbers of people who may be available above the number of graduates who are coming out of Ontario schools. In fact, the 24 positions–

Mr. Andrewes: How do you do a calculation to get an increase?

Hon. Mr. Elston: In paid positions there will be an increase. The unpaid positions will be eliminated, and that has been one of the big issues brought to my attention by the graduates who usually occupy those positions. We will be replacing those people with paid positions. That being the case, those new positions will be available. That in itself, I do not think, is going to solve whether a person ultimately goes to northern Ontario.

Mr. Pierce: Since the doctors in northern Ontario know what the problem is in being able to get doctors and anaesthetists in northern Ontario, what are the answers from the ministry with respect to being able to move these people out into the northern hospitals?

The problem we are faced with is that we have full operating hospitals that are now accepting the fact that they are going to be referral hospitals. In fact, they are giving out news releases that the individual hospital will be only a referral hospital and their comments in the news release are that they can have a patient ready in the air ambulance and at an operating hospital faster than they can prepare the operating room, even if they had a surgeon and an anaesthesiologist.

How do we get past that mentality? If that is the mentality of the existing hospitals in northern Ontario, then I am sure the message is going back to the universities that there are no operating hospitals in the north anyway.

1730

Hon. Mr. Elston: From the standpoint of the universities, I do not think the question of how health care is being delivered out of a particular hospital is of interest to them. With respect to training, they are interested in making sure the person, no matter where he practises, is going to be delivering the same high quality of care as is expected in any of the associations of specialists in Ontario.

That a person may not be able to practise medicine in Sioux Lookout because the board has decided that hospital will become a referral hospital or whatever, is not something that bears on the type or style of training the university community understands as being of concern to them. They are trying to give a student the best training to deliver care to a patient or a series of patients.

I think the only time the universities should be aware of the special needs are with regard to one of the things being indicated to me by people from northern Ontario: that is, perhaps the style of delivery of medicine by the general practitioner in areas where you do not have the same support services, might be the subject matter of a special time of training in a more northern area than we have now. For instance, perhaps there should be some internship positions for Thunder Bay, Sudbury or Sault Ste. Marie, to accommodate what are noted as needs in practising in more remote areas so that people will feel at home doing it.

From my standpoint, the question of getting people to move into the underserviced areas from a medical manpower standpoint has still to be the subject matter of our incentive grants. The people in British Columbia have a different way of pursuing it, and I have been asked in the past several times whether I would pursue the BC method: that is, no license unless you go to a particular area.

I have indicated that my position is to follow the incentive grant system to get people to relocate. I also think it important that we follow the route of providing some support for those people in more remote areas, helping them with their facilities. We have been working along the opening of the new unit at Sudbury, for instance. It is a good support facility for the people who want to practise paediatrics and for the obstetrics of difficult cases. With that taking place, I think there will be an attraction to the facility because people know it can do certain things and they can work with the facilities there to deal with questions of difficult pregnancies or early delivery in that area.

Mr. Pierce: The problem we deal with on a regular basis when we talk about accessibility to health care is that a number of the smaller northern communities that already have full operating hospitals are losing their surgeons and anaesthesiologists because of age and are not replacing them. Accessibility now becomes a major problem to people living in those communities. To get the simplest of operations, such as appendectomies and tonsillectomies, people are now required to travel 150, 200 or 300 miles. That is not accessibility to health care.

Hon. Mr. Elston: Those questions have always been brought up when a person who has been in a community for a long time either retires or has decided to take another position. My community of Wingham is not a northern community but a small community of 3,000 people with a fully operational hospital along the same lines, I guess, as yours. In the mid-1960s we could not find a physician. We as a community had to go all over the place looking for physicians to attract people to come in. We happen to have a goodly number of physicians there now. If I understand what happens, it is very difficult for a person to be in a small community as the first or second physician. You get run right off your feet and you need the support of other colleagues not only to take off some of the weight.

Mr. G. I. Miller: That is the main thing. Advertise the fishing. There are good fishing spots up there.

Mr. Pierce: We do not want to do that, either. You are going to give that one away.

Go ahead; I am sorry.

Hon. Mr. Elston: This is necessary not only to attack the question of work load and early burnout by people in small towns where one or two individuals serve three or four thousand people, but also so that there is somebody else to discuss case load with, to work with and to refer to internally so that you can have some kind of personal support.

All of those concerns were big items when we needed to seek people. Once we got a number of physicians coming out, then it became a much more attractive place to practise as well. However, we went through the same type of problem; I think we always will in the small communities. That means we have to be very aggressive as communities in seeking out people to come in and to bring them in to practise.

Mr. Pierce: But as I have stated, the mentality of the hospital administration boards now is that they are content to be referral hospitals. They are not pursuing surgeons and anaesthesiologists. Of course, the response I get from them is, "The reason we are not doing so is that any doctor or any surgeon in his right mind is not going to come to a small hospital where he is not going to have that many operations, or enough operations to cover the insurance costs with respect to liability."

If that is the direction we are going and if that is the direction everybody is accepting, then we as legislators have to look at a different system in providing the accessibility limits we provide today. Whereas yesterday you could take your child down and put him in the hospital, and he could have that little tonsillectomy and be out of hospital in a day and a half, it now requires five days for the same operation 250 miles away. An operating doctor in a hospital 150 or 200 miles away is not as ready to let the patient out, because he now has to travel 150 or 200 miles back to his home base and he is not available for the doctor to examine upon arrival.

Hon. Mr. Elston: I have two items. First, I am not sure about your days, but I do know in coming back from eastern Ontario–Hawkesbury, Alexandria and in that area, where they refer people either to Cornwall or to Ottawa–they found that the patients who had been referred for surgery, even more complicated surgeries–I am not sure about tonsillectomies or appendectomies–had been referred back even sooner from Ottawa and Cornwall to these other, smaller hospitals, and they found it to be a much better use of their abilities and manpower. In fact, they were feeling happy about the way this was occurring, because they had the people back in the community relatively quickly for convalescence. The same is true with difficult pregnancies. The results seem to be good for them, and the style of practice was helpful for the physicians. It gave the board members of the hospital a level of satisfaction that they were providing what was required in the system of care.

I would be very hesitant when a board of trustees in a small community made a decision that it could provide better care for its community. If it made that decision by making use of the very extensive northern travel equipped emergency service, then maybe this is what should occur. I find it very difficult to legislate that a specialist, a surgeon, should have to go into one small town to do two or three operations a month or whatever the statistics might be and still pay the coverage for the legal liability that he gets himself into. The same is true for an anaesthetist.

From my standpoint, as I plan for this health system, we have to make sure that the people have, first and foremost, the quality of care item down pat. I would far sooner see a surgeon go travelling around the communities performing a large number of surgeries. That is what could take place, I suspect, if the hospital wished to make arrangements, and perhaps we could have a team of people who would travel. The surgeon and the anaesthetist would be comfortable one with the other, and I am sure they would be comfortable with the physical facilities. That might be the better way of doing it than saying, "Surgeon X, you must locate in community Y and deliver that service so that presence will be there."

1740

I was in Sioux Lookout and then went to see the Atikokan General Hospital. You were with me at that place. In one or two of those centres, particularly Sioux Lookout, an orthopaedic surgeon and maybe another one came in regularly, at least two days a week.

Mr. Pierce: In explanation of the Sioux Lookout situation, they also have a hospital that was set up by the federal government and that provides services to the northern Indian communities. It is accessed quite heavily by the people living in Sioux Lookout.

Hon. Mr. Elston: Yes, but the surgeon actually visited the physical facility, the general hospital in Sioux Lookout, to deliver the surgery. I am not even sure what community he travelled out of. From my standpoint, that would be a

superior way of delivering service and of making sure that a person felt comfortable with his competence to deliver the program, instead of being put into a community to deliver a service and not feeling comfortable that he was able to practise enough procedures to stay on top of providing the procedure. I would not want to legislate that.

Mr. Pierce: Let me go one step beyond that. How do you as Minister of Health recommend that small communities construct their hospitals? Are we still designing operating facilities into new hospital construction in northern Ontario?

Hon. Mr. Elston: Yes, as far as I know. The ones I have seen and been in all have theatres in which to provide those services.

Mr. Pierce: Yet we have not addressed the problem of not being able to get surgeons and anaesthesiologists in the small communities. We are saying that the best way is to move the patients out and the hospitals will become referral hospitals; or we are saying that we have not yet decided whether we should move the doctors in and operate on a number of people at the same time or on the same tour.

Hon. Mr. Elston: In certain circumstances I am sure the boards would like to make their hospitals deal with the real world. In other words, if they do not have a surgeon and an anaesthetist who are available all the time, then they must make arrangements to make sure their patients can be transported. That is wise on their part. The fact that we have some surgeons and some other specialists who will travel seems to be a good reason to make use of facilities outside the large centres.

Our hospital system is currently made up of a number of community facilities spread geographically in centres of larger population. I include the facilities that may be in a village of 800 or 900 people as being in the larger centres. It is not an unhappy occurrence to have the larger facilities, where a lot of extra staff people who are specially trained are available, dealing with the more complex procedures.

I see nothing wrong with making use of facilities outside those large centres, which are generally booked quite heavily and where the time pressure is quite heavy for the use of operating time. I see nothing wrong with the surgeons coming from outside the area and making use of operating facilities in the communities for such things as tonsillectomies or whatever. Those can be comfortably dealt with and handled in those facilities. That is a superior way of doing it.

Some physicians have told me that when they have sat down and analysed what was happening, as persons from a small area they would not be able to handle a procedure such as a heart bypass; they would refer that to one of their surgeon colleagues in a larger centre. All of a sudden they discover that all those procedures were being referred on, but the types of procedures that could be handled in small communities were not being referred to them. There was time available in those operating theatres that might be used to accommodate people who did not have as serious a problem.

I am in favour of making use of the facilities wherever they are, as long as we have people who are appropriately trained to deliver a service and as long as we have facilities that are able to accommodate the recuperative requirements of the patients.

Mr. Pierce: Am I to understand that the ministry is currently looking at some kind of program where small communities that have operating theatres would be provided with travelling doctors in order to provide the kinds of operations you are referring to?

Hon. Mr. Elston: The medical specialist incentive program will provide specialists with funding to travel now, if we can find the people to travel.

Mr. Pierce: I am thinking beyond that part of the program to small communities such as Atikokan or Fort Frances that are fortunate enough to still have surgeons and anaesthetists but are afraid they could lose them.

Hon. Mr. Elston: They are not losing them at this moment.

Mr. Pierce: No, they are not. We have our fingers crossed.

I am thinking of a program beyond the program that is available now, which would provide an operating surgeon to move out of Thunder Bay and go out and perform those kinds of operations.

Hon. Mr. Elston: Our program would allow that to occur and in fact would stimulate that, but I cannot say that we do not have one if we do not have one. Our program would help stimulate that type of travel. We recognize that a person who might be able to deliver service from Thunder Bay on an ongoing basis should receive a little bit more compensation if he has to do the travelling himself, which cuts down on the amount of time he has to provide service.

Mr. Pierce: When I wrote to the minister about a woman who was required to take her

child to Thunder Bay from Atikokan for a tonsillectomy, the response was negative with respect to travel grants or any allocations to allow her to travel with her son, which she had to do because he was too young to travel alone, stay with him while he was in hospital and travel back with him. They kept him an extra day in the hospital in Thunder Bay because he was travelling. There is nothing that assists that individual to go out of town for that operation even though there is an operating–

Hon. Mr. Elston: Is it closer than 250 or 300 kilometres?

Mr. Pierce: It is 120 miles.

Hon. Mr. Elston: Whatever that is in kilometres.

Mr. Pierce: It is 240 kilometres.

Mr. Andrewes: It is about an hour and a half.

Mr. Pierce: That is right. It is about two and a half hours in the wintertime.

When you look at how the hospital came to be in Atikokan and at the commitment on behalf of the people in that community to raise the funds to build those necessary facilities, anybody going to the hospital and visiting patients can readily see there is an operating theatre there, but it is no longer usable.

Hon. Mr. Elston: I agree. Circumstances do change over the course of history. That is our difficulty in all small communities right across the province. I come from an area that is not unlike Atikokan, except you have more people than are in my home town.

Mr. Pierce: But you have a surgeon; I do not.

Hon. Mr. Elston: That is right. We have a person who performs surgery, but we have only a part-time anaesthetist. In other words, the practice is basically that of a general practitioner, and he fills in as an anaesthetist.

Mr. Pierce: That is 100 per cent better than what I have.

Hon. Mr. Elston: It is one person better. If that person makes a decision to move to another area, as has happened with young physicians in my town before, then we are left in the same circumstances as you are, with perhaps one exception; that is, within 50 miles we have two or three other facilities from which we can reasonably get some travelling done to fill in. All of us in small communities are at a disadvantage when it comes to attracting personnel. I am not at a stage where I am going to legislate that people must be in certain areas or not practise at all.

Mr. Pierce: You must admit it is getting worse instead of better. We are not progressing in providing health care in small communities throughout Ontario.

Hon. Mr. Elston: No. I disagree.

Mr. Pierce: If you are having the same problem I am having, then we really have a problem.

Hon. Mr. Elston: There are problems in all those small facilities, no matter where you go. I would say our delivery of health care is much improved.

Mr. Pierce: It is dependent on a helicopter being able to get in the air. It is dependent on the availability of a helicopter–

Hon. Mr. Elston: Where there was none before, there is now a helicopter.

Mr. Pierce: It is dependent on the availability of a theatre in a community that already has a population of over 100,000 people. There are a lot of factors, considering that all it depended on previously was being able to get the patient in a car and to a hospital within 10 or 15 minutes.

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Hon. Mr. Elston: That may be right; it may not be right at all.

Mr. Pierce: It was right in a lot of cases.

Hon. Mr. Elston: If you go through the history of those communities, there has always been a bit of a problem in trying to attract a person to make sure that a hospital facility was functioning. Historically, it has been a problem in our area, as it has been in your area.

One of the big problems in being a physician in a rural area always has been not necessarily that you were paid in eggs, chickens and all those other things but that you were probably the lone person–or perhaps with one other, as was the case in our community for a long time–and you worked night and day. That caused some real problems in recruiting others to come in.

The situation now is such that I can have a helicopter come into Wingham, if need be. The service to the people of Wingham is much better because the helicopter can land in a parking lot at the school and can transfer the person to London in most cases, or to Toronto if need be.

The same is true for your situation. In particular, where we have done a much better job of organizing our emergency health services with respect to reacting to trauma, we are much better off in delivery of health care to northern Ontario than we were before. We are much better off in being able to deliver services to high-risk

pregnant women in Sudbury because they can now stay there. Twenty or 25 people who would have gone to Toronto, referred way out of the community, no longer have to go; they can stay there.

Mr. Pierce: There is still a big void out there. Even though you are providing the service in Sudbury, there is still a void west of Sudbury that is wide open.

Hon. Mr. Elston: In any community, you will find a series of problems in terms of needs. From my standpoint, one of the difficulties a person gets into is that if he thinks an anaesthetist for Elliot Lake will solve the problems, then he does not understand the health system; it is continually changing, and we will need all kinds of people to do different things.

One of the other items helping us be more flexible in delivering care is the fact that we have more health professionals delivering services. Even though we need to recruit more physiotherapists, the fact that there are physiotherapists able to deliver service in localities is helping. The fact that we need more chiropodists does not mean the people already there are not delivering a very good service. We are using our public health units to deliver some dental programs. All that stuff has improved. The fact that we are delivering alcohol and drug addiction programs through various community bodies means the health care of northern Ontario and other areas is being improved.

That does not mean we do not have a lot of problems. There are any number of areas where there are not enough speech pathologists, physiotherapists, occupational therapists or people able to communicate in languages other than English to deliver those services. That is always going to be the problem we wrestle with, to make sure we can meet needs which are always changing.

We do not have any centre yet set for training people to provide services to the elderly, but we are working on it and in a short time will end up having a lot of people trained to deliver those services. We have the makings of some very good people. Dr. Ronald Bayne in Hamilton has been working on some facilities. Dr. William Dalziel, who was up in Kenora not that long ago, is working out of Ottawa on some excellent training programs.

Mr. Pierce: Those are all great programs and are no doubt well used by the people of Ontario. That does not answer the problem for the person in northern Ontario who is still required to go to town and then drive a couple of hundred miles for a tonsil operation for a five-year-old. We are still back to square one.

Let me ask you more specifically a couple of questions in relation to two communities in my riding; one is Ignace. Is the Ministry of Health considering a holding-bed hospital for Ignace?

Hon. Mr. Elston: Not at the moment. I do not have a formal application in front of me, but that does not mean I am unaware of their desire to have something more than a pre-op station.

Mr. Pierce: They have a clinic, but the funding to the clinic was cut.

Hon. Mr. Elston: I have not got to the stage of analysing a proposal in my office for a holding-bed facility, whatever that may mean. They would probably be able to get–

Mr. Pierce: If you have some information, can you provide it for me?

Hon. Mr. Elston: I do not know that I have any for you, but I will provide whatever I have.

Mr. Pierce: All right.

Hon. Mr. Elston: I am not unaware of your interest in such a facility, but in terms of the clinic–

Mr. Pierce: The problem is there are some people running around Ignace who are saying that a hospital is going to be built, that the building permit has been taken out and that it should be built by the spring. I do not know whether that will be before the election or just after the election, but that is what the talk is in Ignace. I would like to be able to assure the people of Ignace whether a hospital is going to built, and it should come from a credible source such as the minister's office.

Hon. Mr. Elston: There is a certain timeliness in their attempts to get it off the ground and going, I suspect, but I have not given the approvals for such a development at this stage. I do not know what they are doing. As I understand it, they are working on their clinic, are they not? Are they not augmenting the size of the clinic available there?

Mr. Pierce: They are doing some rearranging of the existing clinic; that is right.

Hon. Mr. Elston: I understand that is happening, but in terms of building bids or whatever, I do not know about that.

Mr. Pierce: Okay. I think it is only fair to the people of Ignace that they have an idea whether what is being is said is true. There are a number of rumours being floated around Ignace by some people that everything is in place and it is just a

matter of getting the sod turned and starting to build the buildings.

I am sure the hospital in Rainy River has been brought up within the ministry. I understand the proposal is to build a multiple-use hospital with a number of acute, chronic and extended care beds. At what stage is the ministry's commitment to the hospital in Rainy River?

Hon. Mr. Elston: We can probably have Randy Reid, who is the assistant deputy minister of Health, institutional health, tell us a little bit about Rainy River. I am aware of their desires. I have even had some chats with the folks from Rainy River. At one point, I met the mayor in Kenora.

Mr. Pierce: Yes.

Hon. Mr. Elston: I am sorry; perhaps it was in Fort Frances when I was there.

Mr. Pierce: Gordon Armstrong?

Hon. Mr. Elston: They brought up the question of our planning, process and procedure, but Mr. Reid will be able to give you more on that.

Mr. Pierce: I believe the town of Rainy River has selected one of three sites and has submitted that selection to the ministry. I wonder where we are.

Hon. Mr. Elston: It has a long history, as I understand it.

Mr. Pierce: The Ministry of Northern Development and Mines committed some money for extended care. The community, through the Rainy River Valley Health Care facilities, looked at adding on to the hospital. There are people in the community who still feel the extended care wings can be added to the hospital. There are two opinions on whether they can.

Hon. Mr. Elston: What is your opinion?

Mr. Pierce: My opinion is that the people in Rainy River will decide what best suits their needs.

Hon. Mr. Elston: That sounds like a reasonable type of position for a local member to take on it.

Mr. Pierce: That is right. Any addition to the existing hospital could be part of the acquisition of property surrounding it. There are a number of factors.

Hon. Mr. Elston: I am looking at the latest information we have, from the middle of December. The ministry asked the chief executive officer "to provide the proposed terms of reference relating to the review of whether or not a new hospital complex should be developed." I take it that since there has not been an update, we are awaiting that material. As soon as we find out what is being proposed, we will take a look at authorizing them to proceed with the review, so we can have a view of what they expect to accomplish.

Mr. Pierce: I believe the ministry is in receipt of some correspondence from a concerned citizens' group as well as from the mayor and council.

Hon. Mr. Elston: I do not doubt we have probably received some. I usually receive concerned citizens' mail on most capital development projects that have either not followed the traditional path or–

Mr. Pierce: There are some fears in the concerned citizens' group, of course, that it could lose its funding from the Ministry of Northern Development and Mines for the extended care wing, which was allocated at the beginning of the year.

Hon. Mr. Elston: I am not sure that is a problem they should think will cause them grief, bearing in mind that the Ministry of Health has agreed to take a look at the possibility of review. I can check, through Mr. Reid, with the people at the Ministry of Northern Development and Mines to ask whether that is a problem. I suspect that is not a problem, because the two organizations work very closely together.

I can tell you that the Ministry of Health prefers working closely with Northern Development and Mines. In fact, the extended care bed program and the EldCap program authorized by Northern Development and Mines has been a great help to the people in northern Ontario and to the development of the community health care abilities in those areas. I do not think we would proceed without advising people that there may be a jeopardy. I would not expect any, but we can check and advise you.

Mr. Pierce: Can you give me any idea of how large a proposal is planned? Can you tell me how many chronic beds, acute beds and extended care beds?

Hon. Mr. Elston: I could not do that, but Mr. Reid tells me we have not seen that ourselves and I suspect that will be some of the information that we will be looking at, and the terms of reference within which the review would be worked on will help them move towards those numbers, but we do not have it yet.

Mr. Pierce: Could you provide me with that information and the estimated costs of the facility?

Hon. Mr. Elston: Since we do not have it, I cannot.

Mr. Pierce: When you get it.

Hon. Mr. Elston: Sure, but it does not mean much until we know what the review is going to accomplish. I will certainly provide you with information. Any member who is letting the community decide, I am sure, would like to know what they are deciding before they go too far.

The Vice-Chairman: Mr. Pierce, that finishes your questions?

Mr. Pierce: Yes, it does.

The Vice-Chairman: You timed that very well. We are now at six of the clock. I will adjourn the session until tomorrow afternoon after orders when we will resume our discussion.

The committee adjourned at 6:01 p.m.

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Legislative Assembly of Ontario

Standing Committee on Social Development

Estimates, Ministry of Health

Second Session, 33rd Parliament
Tuesday, January 20, 1987

Speaker: Honourable H. A. Edighoffer
Clerk of the House: C. L. DesRosiers

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday, January 20, 1987

The committee met at 3:28 p.m. in committee room 1.

ESTIMATES, MINISTRY OF HEALTH
(continued)

Mr. Chairman: We convene the standing committee on social development and I call it to order. We are dealing with the estimates of the Ministry of Health and we are still on the first vote, as I recall.

Hon. Mr. Elston: Actually, we are still on my reply to the opening statements. I had started to address a couple of answers and then we moved into another area of concern.

Mr. D. S. Cooke: Where the hell is my answer?

Hon. Mr. Elston: As I recall, despite the intervention of my colleague the member for Windsor-Riverside, we got into some worthwhile discussions about individual members' concerns, one in particular about ambulances, which took up a considerable amount of time. Then we got into dealing with issues of mental health, as requested by the members.

There are a couple of ways we may progress. It is unfortunate Mr. Pierce is not here today. He was here yesterday to raise questions about Ignace. We have some information on Ignace.

Mr. Andrewes: He is expected back.

Hon. Mr. Elston: Perhaps I will wait for him to come in a little later. Since we may be able to deal with this as the last day of estimates, as I understand it, perhaps rather than listing all my replies to the rather complete opening statements of both my critics, if there are areas of discussion we should highlight, that may be a better way of doing it. If there is nothing in particular, then I will go down the list of questions that were raised and provide what replies I can.

Mr. Chairman: Let us check that out. We have three hours and eight minutes left, which essentially means that if we run through to 6 p.m. today, in theory there will be about 20 minutes remaining. Is it agreed that we complete them today? I see nods.

Hon. Mr. Elston: They were not just sleeping?

Mr. Chairman: No. I definitely saw affirmative nods.

Do the critics have matters they would like to place as priorities to be dealt with in the remaining three hours?

Mr. D. S. Cooke: Can the minister quickly run through the topics he was going to respond to?

Hon. Mr. Elston: I have a full list of things. For instance, one is with respect to health service organizations and community health centres. A letter was read by–

Mr. D. S. Cooke: Just tell us the topics.

Hon. Mr. Elston: Okay. The health professions legislation review was a question you addressed. Later on, we got bits of information from Mr. Andrewes on the Ontario Council of Health and John Evans–on what roles, who, where and how. Hospital funding, operating budgets and graduates from medical schools were among the subjects of Mr. Andrewes's questions. The list goes on. Electroconvulsive therapy was dealt with. I suspect this committee at some point will probably deal with seniors and the nursing home amendments we have introduced, although I am not sure exactly what committee we will appear before.

I have distribution of talents. I think it is really related to manpower. These are my handwritten notes of items that Mr. Cooke raised. Others include: community and public health nurses; the health professions review; the registered nursing assistants; naturopaths–that was raised by Mr. Andrewes initially, but I think both have raised questions about it. There was also a bill of rights, which we can talk about with the nursing home amendments; rest homes; acquired immune deficiency syndrome, which was talked about in questions yesterday; environmental hypersensitivity; public health; seniors; nursing homes–Mr. Cooke raised the Maples Home for Seniors in Tavistock–Extendicare and the follow-up on the deaths in London in September 1985; and inspections in nursing homes, including the profit and not-for-profit split, financial disclosure, advocacy and staffing levels.

The question of whether the committee will travel when we deal with nursing home amendments was raised by Mr. Cooke in terms of trying to give the entire provincial community access to us. The Minister of Health is not aware of that

resolution at the moment, but those who structure the committee's time will know what is happening there.

We had a full day on Bills 54 and 55, so I do not think we need to go into that. The AIDS Committee of Toronto could probably be expanded to deal with other community groups which are just starting to become more formally established now. Physiotherapists and the question of pay equity was raised by Mr. Andrewes; that is one of the agenda items of the new Progressive Conservative Party as opposed to the old, I presume.

Palliative care and access to abortion were also raised by Mr. Andrewes. There must have been something dealing with over-the-counter prescriptions and other items–I have just very quick notes–but I think we have dealt with a full session on Bills 54 and 55.

Mr. Chairman: Have we dealt sufficiently with the problem?

Hon. Mr. Elston: I do not know whether Mr. Guindon has a particular item he wants to raise, but while the critics go through that list and see where they want to put some priority, if Mr. Guindon has a particular question, I think we should address it since this is the last day.

Mr. Chairman: Is there agreement that the two critics will select from that list the ones they are most interested in having debate on, and then we will alternate back and forth between them? While they are deciding on their priorities, Mr. Guindon may raise his particular concern.

Mr. Guindon: While the minister was visiting the Cornwall area last week, he was speaking with those concerned with health care providers. At the meeting, I am sure the situation regarding chronic care beds was brought up. The situation in Cornwall and the whole area is pretty desperate. Have you made up your mind or have you decided on the allocation?

Hon. Mr. Elston: No. In my reply to Mr. Follon, the board chairman at Hotel Dieu Hospital, I indicated that we had not yet made up our minds. We have received a recommendation from the district health council on the allocation of chronic beds in the planning area. I have not yet received the recommendations through my office. They are being worked on in conjunction with all the recommendations for the area, and I will probably have a package to deliberate upon within the month.

I have to repeat what I said to Mr. Follon. No, I have not made a decision. I know of their intense interest in extra chronic care beds. As I underscored at the meeting, the reason for the meeting being held in Cornwall was not in itself to address specific issues such as those–because we are very much aware of their interest in those chronic care beds–but to take a close look at the co-ordination of a large number of services in a manner that would allow communication to flow among the various providers.

It is an unusual situation to have hospital administrators and board chairmen at the same meeting with people who provide home care, with owners of nursing homes–there were a couple of those; one was only an administrator and the other was an owner-operator, as I understood it–the co-ordinator for psychogeriatric services, members of the district health council, a couple of physicians and the medical officer of health for the area.

Setting up the forum in that manner meant there was an exchange of information and ideas among people who would not normally be there, to get a more global perspective for all those in attendance. What happens for all of us–and the Minister of Health is no different–when we are dealing with particular issues is that we get our attention focused on one small corner of a vast and complex area of service delivery. That is why I was there, not to deal with the question of chronic care beds for Cornwall or for the counties of Prescott and Russell, but to take a look at what might be needed.

I was very pleased with the forum and the fact that Dr. Bourdeau, who is the medical officer of health there, actually brought together some suggestions for dealing with the problems that had arisen. Suggestions were made by individuals that we look at particular problems and how we might get some solutions. It helped for us to reflect on the concerns of people who have to cut across various funding programs delivered by the Ministry of Health or provided by other ministries.

There is no decision on the chronic beds.

Mr. Guindon: I am sure you have been made aware that both hospitals are at about 100 per cent capacity, that a lot of elective surgery is being cancelled and that dates are being changed. Some people in my riding have been put back three times. What is your view on that?

Hon. Mr. Elston: Interestingly enough, the question of someone receiving surgery obviously is dealt with by the physician; he or she must determine the priority of each person who enters a facility.

The encouraging part about visiting the Cornwall area was my visits to the Hawkesbury

and District General Hospital in Hawkesbury and the Glengarry Memorial Hospital in Alexandria. I discovered that in both of those locations there was now a much heavier use of those facilities by Cornwall and Ottawa for the purpose of rehabilitative work on patients who had received surgery.

That indicates to me that the hospitals are co-ordinating their efforts much better to help generate increased use of the beds available in the area. It is a reflection of a growing recognition by more major hospital centres–Cornwall is in that area–of the resources at their disposal; in that case, in Alexandria. I was happy to see those referrals going back and forth. That helps us make better use of the beds available in Cornwall and perhaps helps keep the statistics high in terms of bed occupancy. They are bringing people back to another area for the rehabilitation.

That being the case, I do not doubt physicians must postpone elective surgeries on the basis that there are people already in the beds who are receiving some medical treatment in the hospital, but that pressure has helped to make better use of the smaller facilities. We have to take a look at how much the occupancy is on the basis of any people inappropriately placed in those beds.

One of the reasons we announced more chronic care beds for the area–not only for your area but also for Ottawa and the entire province–was that we found that roughly 20 per cent of our patients are said to be inappropriately placed. It might very well be a chronic bed or a nursing home bed, or it might be the subject of a community support program such as home care or an integrated homemakers program.

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Putting that entire system in place is going to take us a little time, but we are going to be able to alleviate some of those pressures. That is helping us stimulate the discussion about whether a person is appropriately placed, whether more facilities are needed or whether a different sort of facility is needed.

The point was very well made during the course of the day that, for instance, people being placed in nursing homes might look to chronic care beds or someone in a chronic care bed might be activated to a state where he or she could appropriately receive chronic care from the home care program or be placed in a less intensive nursing facility.

That being the case, many of us see that we are on the right path in helping people address the question of electives. Elective surgery is often postponed because there are no beds, rather than because the operating theatres are unavailable. With that in mind, we are putting more chronic care beds in that area. We are looking at what is required for nursing home beds and what would be available when we implement the integrated homemakers program for the area as well. All of those come together to provide us with an overall system, which I think will help them deal with the question of elective surgery cancellation.

Mr. Guindon: I have a comment and then a question. Cornwall has a hard time attracting doctors. Our area has always struggled to get doctors. In our area, we miss ear, nose and throat specialists. If you know of an application that comes in, you may send it our way.

My last question is this: Does your ministry have a record of the doctors who are now billing legally for services not covered under the Ontario health insurance plan since Bill 94 has been passed? I want to get at your $50 million. Are you saving it, or is it costing people more than $50 million?

Hon. Mr. Elston: First, let me comment on your comment. During the height of our discussions on Bill 94, it seemed there was a very large number of physicians in Cornwall. I remember receiving volumes of correspondence from the area. In any event, I recognize the need for particular specialists in any given area.

If there is a need for an ear, nose and throat specialist, perhaps we could check the people who are graduating with that specialty to see whether there is someone who might be interested in pursuing a career in Cornwall, which, as I understand it, is increasingly providing more procedures for the area. In fact, doctors in Cornwall are pushing their area of referral a little farther and helping to take some pressures off the Ottawa area. I can take a look at that.

On the question of the $50 million being saved, I am not sure I understand what the question is getting at. The $106 million we received back–I guess it was $104 million-plus, not quite $106 million–that was on holdback, has all been allocated to health care spending and will get put back into the system.

The so-called extra billing money was actually money that came from patients' pockets. The essence of the Canada Health Act was that if the patients were paying that money, the government of the province in which that occurred would pay a penalty of a dollar amount equal to that being extra billed. From that standpoint, ending extra billing really keeps the money in the pockets of the patients. It really does not assist the government in that manner to save money.

Ending extra billing allows us to have access to money that the people of Ontario are already entitled to receive from the federal government. We were going to be penalized if we allowed the patients to pay. From that standpoint, we have saved the patients of the province money.

That having been said, however, it is clear to me that there are certain areas in which physicians have been very creative with respect to charges. It is not a large number of situations, but in some areas, particularly obstetrics and gynaecology, there have been charges. We are still pursuing those situations. Where there are cases of extra billing, of course, under our legislation we can reimburse the patient, and we have chosen to do that first and foremost. We then are in a position, after we know exactly who has been charged and what is being charged, to pursue collecting money from the people who have charged extra. According to our current statistics, about 95 people have been reimbursed for a total somewhere in the neighbourhood of $5,300, so it is not a large amount.

That having been said, for those people who have been charged, they have not saved that money. In fact, we have reimbursed those people who have complained. We recognize that there are some areas in which people have not lodged complaints about receiving extra charges. For instance, in some areas of continuing care, such as obstetrics, we expect that someone might choose to complain after the arrival of the child and an appropriate convalescence time. We are not putting a time limit on people complaining about it; we want the patient to feel comfortable with the system. We will be dealing with those situations, and from that standpoint, those people will be saved money.

Mr. Guindon: What I am getting at is that in Cornwall there are no doctors who extra billed, even if they were very vocal. I am getting some complaints from time to time in my riding office about charges for telephone fees, for letters or whatever. It is not that much. My question to you is really, are you saving any money across Ontario, or are the people of Ontario saving any money now as compared to before?

Hon. Mr. Elston: Generally, the case is that they are. There are people who have introduced fees for those services. In fact, in some places the uninsured service fee is almost a decade old. The first statement on it was issued by the College of Physicians and Surgeons of Ontario way back in 1978.

That being the case, it does not mean we are not concerned about those charges being levied. Since we are now in the course of dealing with negotiations and other things with respect to fees, it will be of interest to us to review the progress that has been made.

Mr. Guindon: Thank you.

Mr. D. S. Cooke: Have any doctors been charged yet?

Hon. Mr. Elston: No, they have not been.

Mr. Chairman: Mr. Pollock has indicated an interest in this. Can I get an idea from the critics first, Mr. Pollock, if it is all right with you, just what their priorities are, how you have decided to divvy this up?

Mr. Andrewes: I would like to spend a bit of time on the whole question of financing programs to support victims of acquired immune deficiency syndrome. Mr. Cooke and I both would like to explore the issue of foreign medical students. I would like to spend a brief time on palliative care and perhaps have an answer to my two questions on abortion.

Mr. D. S. Cooke: There is some overlap of foreign doctors and the health disciplines review. We would like to get an idea of the timetable. I would not mind something short on rest homes and what the plans of the ministry are; an update on the phasing in of the assistive devices program; an answer on the questions to do with Caressant Care, both the Woodstock situation and St. Thomas one, where Caressant Care took over some homes and transferred residents.

1550

Hon. Mr. Elston: We can probably do that at the same time as we are handling Tavistock, the same sort of–

Mr. D. S. Cooke: That is what I meant: Woodstock and St. Thomas.

Hon. Mr. Elston: I am sorry.

Mr. Chairman: We have a fair number of matters to raise. Shall we take a minute or two to hear Mr. Pollock? Is that all right? We have a lot to deal with in the next two hours. Can we give Mr. Pollock until four o'clock? Then you will have two hours to divide between you to try to cover the rest.

Mr. Andrewes: We will attempt to make brief interventions, if the minister will attempt to be brief.

Mr. Chairman: I will attempt to keep everybody brief.

Hon. Mr. Elston: Sometimes I find that we have done so much that it is difficult to keep it brief.

Mr. Andrewes: So I have noticed from reading the Hansards.

Hon. Mr. Elston: If the chairman rules that I have certain items that are too numerous to mention, I will cease and try to do it by letter or something.

Mr. Chairman: I may have to do that from time to time. Supplementary letters would be welcomed.

Mr. Pollock: I am concerned about nursing home beds in the village of Norwood. I do not know whether you know the whole history of that, but there used to be a nursing home in Norwood by the name of the Spruce Haven Nursing Home. It had 33 beds. The operator wanted to get out of the nursing home business, but there seemed to have been a problem. Even though she got a fair offer for her licence, her property and everything, she did not accept it. They eventually moved all those beds to Marmora to the Fabeth Nursing Home.

I understand a deal has been struck by a new owner to buy her licence and establish a new nursing home there.

Hon. Mr. Elston: In Norwood?

Mr. Pollock: Yes. This person wants another 12 beds, on top of the 33 he is supposed to get, to establish a nursing home there. It is a major concern to me and the people in the Norwood area. There is no nursing home bed there now. In fact, I do not believe there is a nursing home within 20 miles of Norwood at present.

Hon. Mr. Elston: Peterborough is the closest.

Mr. Pollock: Peterborough or Marmora; it is a toss-up.

Hon. Mr. Elston: I was trying to recall the name. Was it Spruce Haven?

Mr. Pollock: Yes.

Hon. Mr. Elston: I do not recall it at the moment.

Mr. Andrewes: It is in this book.

Hon. Mr. Elston: There are books with respect to each of them. The assistant deputy minister and I were comparing notes with respect to it. It is one that has been in abeyance for a while.

I am concerned that people understand that there is no sale of licences. In fact, when a person decides to sell a facility, he must return the licence. Then there is an inspection procedure in place to require a person to do certain things, whether he is buying an existing building or building a new one, and to require his compliance with our various regulations. That being the case, conditional approval is given on the basis that certain things are done. A new licence is issued for that facility under the name of the purchaser of the building. Technically, we do not sell licences.

One of the concerns I have had since I came to the ministry—actually, even before I became Minister of Health—was that in a number of communities we have small facilities that serve the needs of the community in general. They are there for particular reasons. They probably grew up originally because people did not want to be transported to a home for the aged; they wanted to stay in their local area.

That being the case, smaller facilities sometimes have difficulties that require some changes to their physical plants to allow them to function better—I am sure in this case the wish is that they had a few more beds—or they try to consolidate numbers to build a larger facility.

I have difficulty with approving moves of nursing home beds from one community to another when I look at it as a community resource. I find it difficult to make those approvals unless I am convinced there has been a lot of consultation at a community level and arrangements can be made to accommodate the people in the area who are making use of the facilities.

With respect to Norwood, I do not have any beds or licences available that I know of on which I have been able to make announcements. We are looking at a 4,500-bed thing that the previous government had announced in the middle of very trying times in April 1985, to deal with—

Mr. Andrewes: It was February, if I remember correctly.

Hon. Mr. Elston: It was actually in April. The official announcement came on April 17, 1985, for 4,500 beds right across the province. Anyway, we are examining that with a view to taking the pressure off the need for nursing home beds across the province.

Mr. Chairman: After the subcommittee reports?

Hon. Mr. Elston: No. Actually, we issued some requests for proposals in Ottawa last week, some 70 beds, for instance. We answered proposals for two facilities in Ottawa last week as well, for a total of 70 beds: one to the Elisabeth Bruyère Health Centre, to be operated in its facility in downtown Ottawa; the other to Woodroffe Centre, which is sponsored by the Ottawa Civic Hospital, both not-for-profit organizations, to deliver services there. We are examining what we require in conjunction with

our home-care programs before we make any blanket announcements.

Mr. D. S. Cooke: You have taken the freeze off. What is your expectation of how many beds you are going to put in place across the province?

Hon. Mr. Elston: We probably will be licensing some existing beds. We will probably know the total when we get there. We will be examining areas such as Ottawa, where I did the 35–

Mr. D. S. Cooke: You must have some idea.

Hon. Mr. Elston: I do, but I am not yet able to communicate those numbers to you.

Mr. D. S. Cooke: You know what you are doing, but you do not want to tell anyone.

Hon. Mr. Elston: That is right. I know what I am doing because I am co-ordinating it with home care and integrated homemakers programs. We are examining area by area, and then we will be making determinations–

Mr. D. S. Cooke: There has been a policy decision on how many beds are going to be allocated province-wide, and you cannot tell this committee, which is examining your estimates.

Hon. Mr. Elston: I have made a decision with respect to Ottawa and announced that. I made a decision with respect to Northbrook, near Kingston, which has been announced. Full announcements will be made over the next several weeks, I suspect.

Mr. D. S. Cooke: Concerning the beds that are going to be issued in Ottawa, the proposals that have been called for, how many of those beds do you think will be in the nonprofit sector?

Hon. Mr. Elston: Thirty-five beds–

Mr. D. S. Cooke: What are you putting in place to try to get them in the nonprofit sector?

Hon. Mr. Elston: Thirty-five beds have already been issued to Elisabeth Bruyère and another 35 have been issued to Woodroffe. Both of those are nonprofit, so there are 70 there. There is another request for proposals, which will be going out later this spring or summer some time, which will then be open for the regular competition. During the announcement I indicated that there would be, again, emphasis on the nonprofit.

Mr. D. S. Cooke: I do not understand how that works, though. There is an emphasis; that is your desire. What practical things are in place that are going to encourage nonprofit?

Hon. Mr. Elston: Two things occur, and we will get back. One of the things that happens is that we do not have a lot of people who have operated not-for-profit homes, but there may be community interest groups that will be interested in applying for those homes. We will assist them. We will not use the fact that they do not have any experience in delivering the service as the sole criterion for whether they compete with somebody who has been in the business for a long time.

For instance, in Northbrook I understand there are two particular groups that are interested already, and there may be others. However, concerning the two I found out about, there is a municipal organization that might be interested in sponsoring an answer to the proposal call, and also a citizens' group, whose name I am not sure of. Anyway, I met a couple of people who are members of that citizens' group who have already held some meetings and are interested in putting something together.

We will assist them, and the fact that they just do not have the experience or track record, as it were, will not be used against them when we review what they propose to deliver in terms of care. The Woodroffe Centre, for instance, has not delivered any care yet, but that was not used in determining its proposal vis-à-vis others who applied.

Mr. Chairman: I am going to have to go back to Mr. Pollock.

1600

Mr. Pollock: The Tweed and Area Community Care Inc. group is putting a proposal together.

Hon. Mr. Elston: In Tweed?

Mr. Pollock: Yes.

Hon. Mr. Elston: I have to give you the same answer, but I will review your request. I think the interesting element in discussing nursing homes and the level of care provided in them is that a number of communities would like to see additional facilities in their areas. I think the community in general is quite willing not only to see facilities developed but also to act in a manner to monitor the quality of care delivered. From my standpoint, that is an encouraging sign.

The smaller communities tend not to have received these benefits. Mr. Pollock and I come from areas that are not dissimilar in the size of communities. We all understand the merit of having a facility close at hand, relatively speaking, to native areas, so I will take a look at what is possible, but I have no announcement to make.

Mr. Pollock: As you and I both know, to have a viable operation, the basic number of beds for a nursing home now is approximately 60. There is

not that kind of demand in each small town. It should be spread out, so that when there are two or three small towns or villages in an area–the Norwood area takes in Hastings, Havelock and quite a few local townships right around there. When you get over in the other area, 50 miles away in the Tweed area, there are Tweed and Hungerford. There are roughly 7,000 people in that area. There is a need there also.

Hon. Mr. Elston: I recognize that as a very beautiful area of the province with a very nice winding road that leads into the village's outskirts. We are interested in the use of those beds in a community manner, which you describe, because we like to see our seniors retain the contact with the communities in which they were raised or lived for many years.

I am not sure exactly that 60 beds are a guideline of viability. It has been used as a matter of convenient reference for the association, and probably the ministry, in setting up some kind of funding determinants. It is used as a measuring device. I have seen other areas where people have operated smaller homes very well and delivered good service at the level of funding provided.

In addition to that, we have some areas in northern Ontario, of which Mr. Pierce will be well aware–for instance, in Atikokan, where we have delivered smaller units of extended care beds via the use of hospital hosting under EldCap. There are other ways of looking at those without getting into whether they should be purely–

Mr. Pollock: That 60-bed figure applies if you are starting from scratch. If you are already partially established, you can no doubt get by with fewer beds than that and still survive.

Hon. Mr. Elston: I think it is a convenient reference point in any event. I am not sure whether we can say automatically that if you do not have 60 beds, you are going to go under. I do not think that is appropriate. In any event, we will examine the Tweed situation in the context of Norwood and others that I am sure would like to have extended care beds.

Mr. Pollock: It was the wish of the Haliburton, Kawartha and Pine Ridge District Health Council that the beds that were in Norwood would eventually come back–they were supposed to stay there–but nobody wants to get involved. There was a problem making a deal with the owner of the Spruce Haven Nursing Home for the property and the beds. They could not seem to make a deal, and eventually it had to be moved to Marmora.

Hon. Mr. Elston: If we take a look at the extended care bed as a community resource and measure what is happening with it from that standpoint, it may allow us to reflect more consistently on the question of whether there was an intention to have them moved and then moved back, or what actually was taking place. It is one of those questions for which we see a number of competing interests. When you deal with the concept of having people receive service in a community, you also take the question of ownership into mind. In some ways, that is what the select committee will probably be adjudicating.

From a general standpoint that with respect to the proposal calls that have been awarded to this date, I will give two or three examples: One was in Ottawa, which as I said before went to not-for-profit. St. Luke's Place in Cambridge, which I believe is operated by the United Church, was a not-for-profit award. We also had a very fine proposal from a for-profit organization in Waterloo that had a very high community rating. When we measured programs in answer to the requests, we compared the programs that were being offered and we opted in that one case for private operators. It is not clear cut in each case. We are looking at what programs each is undertaking to provide.

Mr. Chairman: Mr. Pollock, I am going to have to move on if that is all right, unless you have further questions. I appreciate your coming to the aid of the people from Centre Dummer and those other people who would love to have something around Norwood as well.

Hon. Mr. Elston: What about Corbyville? Is that near?

Mr. Pollock: It was, but it will not be.

Hon. Mr. Elston: It is, but it is not going to be after the next election.

Mr. Chairman: Mr. Miller has a supplementary.

Mr. G. I. Miller: It raises an interesting point. Is there a move to locate or a request to the ministry to build nursing homes in conjunction with hospitals so that they can share some of the facilities?

Hon. Mr. Elston: We are not forcing hospitals to make applications, but a number of hospital facilities in southern, eastern and central Ontario have expressed an interest. In the north, however, the EldCap program is put together on the basis of hospitals being hosts to extended care beds. Extended care wings are actually being added to hospitals at Atikokan, Blind River,

Chapleau, Wawa and Rainy River, about which we spoke a little yesterday.

The discussion we had about Rainy River was the fact that we had approval to go ahead with extended care beds and now we do not know whether we have a hospital to host it. I think that was the essence of the question from Mr. Pierce yesterday. From my point of view, it seems reasonable that if there is a hospital that is really a community facility, operated by community boards or trustees of a hospital who are willing to look at providing services, it should be allowed to participate in the process when beds are put out for a proposal call.

Mr. D. S. Cooke: There are those who will argue the opposite for reasons of philosophy.

Hon. Mr. Elston: I was just going to put to you the other side of the question, that we still must examine what is going to be provided from those facilities in terms of service. I cannot just say that the hospital itself will be the appropriate place if it is not going to put in place programming the seniors need. There are reservations that Mr. Cooke might elaborate on a little later that say that you still have an institution base and that may not be acceptable or whatever.

I think we have put together a complex system that provides community support of integrated homemakers, both acute and chronic home care programs. When we add the contractual relationship between the ministry and nursing home operators for activation and build better facilities for chronic care, we are going to have a very complex system of levels of care that I think will assist the people to have reasonable choices about the institutions and facilities they use.

Mr. Chairman: Perhaps we can move to Mr. Pierce's question from yesterday.

Hon. Mr. Elston: That was on Ignace and the holding beds. As I understand it, upon further checking, we have discovered that a proposal was submitted to the health council by Ignace for a hospital or for holding beds. It is my understanding, although it has not come through to us officially, that the recommendation that either a hospital or holding beds be developed was not supported by the district health council. That is the latest I have on it. It does not appear there is a recommendation from the health council to forward that proposal.

1610

Mr. Pierce: Can you date that for me? When was the request for the holding beds? Was it a recent request or is it an old request?

Hon. Mr. Elston: The famous black book fails to reveal a date specific to the issue.

Mr. Pierce: The reason I ask is because there have been a number of requests in previous years by the municipality of Ignace and I am wondering whether that is a request within the past couple of years or whether the request was on the books five years ago.

Hon. Mr. Elston: I think the information I have is from a more recent request. It is not from two or three years ago, as far as I know. We can check further. I will have to write you a letter to give you the chronology so you can be sure of it. It is my understanding that it is a recent request and that it was not supported by the health council, but I will check to make sure of that.

The Acting Chairman (Mr. D. S. Cooke): Since Mr. Cooke is not here to ask questions, we will go to Mr. Andrewes.

Hon. Mr. Elston: Before we start with Mr. Andrewes, the member for Cambridge (Mr. Barlow) also has come in. Our habit is to deal with the questions of individual members. We are quite willing to entertain it briefly and then we can go on.

Mr. Andrewes: It is up to the chairman.

Hon. Mr. Elston: I appreciate that since Mr. Cooke is not here you cannot participate in this discussion.

Mr. Barlow: I just meant to observe what was going on but I would be pleased to ask you a question.

The Acting Chairman: Forget it.

Mr. Barlow: Our colleague, Mr. Miller, asked me whether I had a question and I said only if the opportunity arises, and it appears it has arisen. I recently received a copy of a letter from Cambridge Memorial Hospital. I do not know whether it has crossed your desk yet or not. They have a very sincere concern about funding this year. I am sure you have not heard that before; I am sure it is a brand new problem in your ministry. They feel there is going to be a shortfall of some $636,000 or about 2.3 per cent of their total current budget. If you have not personally seen the letter yet, they have given the reasons behind it. They are requesting that your answer be forthcoming as to how you might address this problem.

Hon. Mr. Elston: We have received a number of letters from facilities around the province with respect to projections and our people in the institutions branch are dealing with each of those projected deficits on the basis of the finalizing of

quarterly reports. We now are waiting for the third quarter to come in to see exactly whether the projections are living up to what the actual figures are showing. We analyse in the third quarter reports and then we know much more specifically what has to be done to meet needs in various areas.

It is interesting to note that the Cambridge hospital actually was one of the groups that responded to the call for proposals on nursing home beds. They were awarded ultimately to St. Luke's Place, so it would seem to me there was some indication that the facility, during the summer and fall of 1986, had a financial position buoyant enough to accommodate the construction of extended care beds and to provide the requirements of programs for those people. We have to look at exactly what the circumstances now tell us about the reports as they come to us. That is the process our institutional branch people are much taken up with these days.

Mr. Barlow: I think you will find that is entirely separate from the operating budget. The fact that they were budgeting for and seeking approval for nursing home beds–

Hon. Mr. Elston: I have to differ with you slightly because it is the hospital none the less that is taking on the commitment of operating extended care beds. There must be some sense of the trustees and the administrator of that facility that they could accommodate the planning and requirements necessary to operate those extended care beds. Whether they want to do it separately or not, it still has to be taken into consideration that this is a public hospital looking at sponsoring those additional responsibilities. That is all I was saying in relation to the types of programming that the proposal was asking them to submit to us.

Mr. Barlow: I know from my meetings with the hospital that it was planning and was desirous of bringing on those nursing home beds. There is a nursing home wing being built now, but it is going to be managed by a private concern, Versa-Care Ltd.

Hon. Mr. Elston: I think it is going to be managed in the contract with the hospital.

Mr. Barlow: What they are concerned about is that this $636,000 projected deficit is strictly on the operation of the hospital per se, with all the auxiliary services that go along with a normal hospital.

Hon. Mr. Elston: I appreciate the member bringing the local concern to my attention. I know the members of the hospital auxiliary there will be much taken with your initiative to save their facilities.

Mr. Barlow: Particularly the recent life member, I am sure.

Hon. Mr. Elston: One of the most recent life members of the Ontario auxiliary, who showed her affection in an appropriate manner to the minister when he presented her with her certificate, indicated her support for the hospital and also for the community.

Mr. Barlow: She showed me the picture of it.

Hon. Mr. Elston: If you have a picture, I would very much like to have a copy.

Mr. Barlow: I do not have it with me.

Mr. Andrewes: Are you a life member now?

Hon. Mr. Elston: I do not think so, but I must say the auxiliaries are an extremely important part of the hospitals. Although I just shared a bit of a light moment, I do not think our hospital system can work without them. In fact, they are one of the reasons our budgetary positions within hospitals are much better in a number of ways than they might be if the fund-raising was not undertaken by them.

Mr. Barlow: I was going to say in conclusion that I would appreciate your answering the letter as quickly as possible because I sure that if you do not, I will be after you.

Hon. Mr. Elston: I think it is fair for me to tell you that we can review the projections of deficit as quickly as people finalize their third quarter reports. It is very difficult to start dealing with issues of deficit on the basis of only half a year when revenues and costs costs may change in terms of the operations on the facilities. Our people in the institutions branch are very much involved now in reviewing a number of individual hospitals around the province that have projected deficits.

I might just say that assisting me today is the assistant deputy minister, R. H. Reid, who is responsible for institutions. He is doing so in the absence of the deputy minister, Dr. Dyer, whose mother-in-law passed away this morning. It might be appropriate to note the passing of Dr. Dyer's mother-in-law and the sympathy we might extend, as members, to the family.

Mr. Chairman: I am sorry to hear of that development in Dr. Dyer's family and I am the first to welcome Mr. Reid to our table. Let us now move to the list of items the critics wanted to cover. Let us start with Mr. Andrewes with the acquired immune deficiency syndrome program.

Mr. Andrewes: Just briefly; yesterday we spent some time in question period on the issue of funding of education and support programs and of the proposed hospice. It is my understanding that the federal government has about $7 million in support of AIDS programs, of which about 10 per cent goes towards education and support groups. The province is funding the AIDS Committee of Toronto on a joint basis with the federal government and ACT as well is doing some–

Hon. Mr. Elston: Our joint basis is much bigger than the federal joint basis.

Mr. Andrewes: Yes. They are doing some fundraising on their own. I am not complaining. I do not think I can express concern on the part of ACT. They were quite concerned six months ago, but now they are quite happy, for the moment as you are well aware. Things change from time to time.

I did not want you to take my comments lightly yesterday when I suggested that from a $9-billion to $10-billion budget, $220,000 or whatever it is, is a drop in the bucket. Surely this issue, the social stigma attached to the virus and the public concern warrant the Minister of Health addressing it in a much more substantive way. I do not think you disagree with that.

1620

Hon. Mr. Elston: Do you mean substantial as compared to substantive?

Mr. Andrewes: I mean both.

Hon. Mr. Elston: Okay.

Mr. Andrewes: If you need one of them.

Hon. Mr. Elston: What is it I can do to help?

Mr. Andrewes: It invites a great opportunity, particularly when you get community-based groups that are willing to go and work in the streets and in the communities with the high-risk groups. It invites you to come to the support of those efforts and to do it quickly. I would like to hear your response to that and your response to any plans you might have to expand, particularly education and support programs.

Mr. D. S. Cooke: As the minister is responding, perhaps I can add my question and my support for what Mr. Andrewes is saying. Beyond the commitment to fund the other groups in other communities comparable to the AIDS Committee of Toronto and some of the other services such as the hospice proposal, what exactly are the ministry's plans in terms of overall community education? What is our comparable program to what is happening in Britain? With all due respect, minister, your comparison of the national government's responsibility in Britain to the national government's responsibility here in Canada is not terribly relevant when the national government in Britain delivers health care. There is no comparable provincial Ministry of Health in Britain.

The responsibility for public health and public health education lies primarily with the minister, whereas the primary responsibility for research lies with the federal government. What is our comparable program and what is coming out in terms of the interministerial committee that exists? What programs have been developed in the Ministry of Education? What is happening in the classrooms of Ontario schools to teach students about the acquired immune deficiency syndrome?

Hon. Mr. Elston: Let me comment first on your mid-point premise with respect to my comments on the responsibilities of the federal government. We are all aware that the national government in Britain has a particular corporation that delivers health service. The responsibility for delivering health services is under that national corporation and it delivers those services. Apart from that is the role played by the national government with respect to what it is doing with educational work dealing with AIDS. There is a $40-million program. I think that was what your statement was and it is the number that is familiar to me.

Mr. D. S. Cooke: They do not have two levels of government.

Hon. Mr. Elston: However, they have separated the way in which they deliver services. Our Constitution provides a separation in the same manner with respect to AIDS because it is a health matter that has no respect for boundaries. There is a national requirement. In fact, the Honourable Jake Epp, the federal minister, has taken this as one of his items of priority. Not only is he allocating $7 million–I think that is the right number; we do not know how the amount will be divided up–about which he has announced some steps, but he has also indicated that he is willing to enter into some experimental work with respect to the drug AZT, developed by an American company, to see whether patients with AIDS respond to it. That is going to be his priority.

Mr. D. S. Cooke: What is going to be this government's response in terms of public education?

Hon. Mr. Elston: As a result of that, he has indicated that the national government has a

reason for being very much involved in it. They also have set up the National Advisory Committee on AIDS, with some very good work being done by Dr. Alastair Clayton and Dr. Norbert Gilmore, who are frequent communicators for information purposes and who relay information to the Provincial Advisory Committee on AIDS, which is a response made here in Ontario. As well, they are working with–

Mr. D. S. Cooke: You are not answering the question.

Hon. Mr. Elston: –materials developed by the Ontario Public Education Panel on AIDS, which is a particular response from this province for educating the public. We make the materials that are disseminated by some of the community groups, about which you and Mr. Andrewes are very well aware. We help them to deal with the budget. In the case of the AIDS Committee of Toronto, we help them disseminate the information in the community. That seems to be a reasonable response.

It seems to be a reasonable response as well to have OPEPA developing the latest information in pamphlet form, which can then be made available to public groups such as parent-teacher organizations and boards of education. Whenever the board of education or a teachers' or parents' group or any community group wishes, we will give it the information.

Mr. D. S. Cooke: What is the plan of the Ministry of Education? What is the recommendation of the Minister of Health on what should be happening in the classrooms in Ontario?

Hon. Mr. Elston: With respect to the Ministry of Education, you will have to go there.

Mr. D. S. Cooke: You are taking the primary responsibility in the interministerial committee. Your ministry is taking the lead role.

Hon. Mr. Elston: We have developed the information that is reasonably required to educate people in a sensible fashion.

Mr. D. S. Cooke: What a pile of crap.

Hon. Mr. Elston: That you do not like the fact that we are putting out the information which is most recently available for the use of the public is perhaps your difficulty.

Mr. D. S. Cooke: It is a disgrace that you guys are not showing any leadership.

Hon. Mr. Elston: The stuff we are generating for use in classrooms or whatever forum is used right across the nation of Canada as far as the territories, and we have received congratulatory notes from all those people for this information.

Mr. D. S. Cooke: So you write the pamphlets.

Hon. Mr. Elston: That is very important. Do you not think it is important? One of the prime things that is done by the AIDS Committee of Toronto is the development of primary pamphlet material.

Mr. D. S. Cooke: There is a little more to the problem than that.

Hon. Mr. Elston: They have shown some ability to get the message to their community. You do not seem to like the idea that there is an educational role to be played by these people, but that is a very important aspect of AIDS.

Mr. D. S. Cooke: That is a pile of crap. That is not what I said at all. What I said was that there is an interministerial committee, and that it is your responsibility. You are the lead ministry and you have done nothing.

Hon. Mr. Elston: You said you do not particularly like what we are doing in providing information on the basis of what information is available for us.

Mr. D. S. Cooke: With $200,000 out of $10 billion, you have done nothing in terms of a leadership role.

Hon. Mr. Elston: That is not right.

Mr. Chairman: Order.

Hon. Mr. Elston: You are not right, Mr. Cooke.

Mr. Chairman: Order, just for a second.

Hon. Mr. Elston: He is not right.

Mr. Chairman: It is possible that he is not right.

Hon. Mr. Elston: It is not only possible; it is right that he is not right.

Mr. Chairman: If I might try to get a little control of the meeting for a second, I am not sure the term "pile of crap" is appropriate.

Mr. D. S. Cooke: Is it correct?

Mr. Andrewes: It is the liveliest thing that has happened in this committee in the past three weeks.

Mr. Chairman: I must admit it did stir me, and this is a good thing. I think we should be a little more cautious.

Mr. D. S. Cooke: I would like some specific answers from the minister about what is coming out of the interministerial committee, in which his ministry plays the lead role and in which the Ministry of Labour and the Ministry of Education are involved. I forget which other ministries are involved.

What is happening out of that interministerial committee other than pamphlets being prepared by your ministry, which are being sent upon request to parent-teacher groups, teachers' organizations or boards? What leadership role is being shown to provide public education about the virus AIDS?

Hon. Mr. Elston: With respect to the gentleman's indication that $200,000 is all of our response, it is not all of our response. The $200,000 you are talking about deals with one group involved in providing material and information to the community. That is $200,000 to ACT.

Mr. D. S. Cooke: How much have you spent, then? Correct me.

Hon. Mr. Elston: There have been other expenditures. We have almost $1 million in research. For instance, right now we have $915,476 to the University of Toronto project for research. We have $888,320 to the Hospital for Sick Children. We have $109,421 to another project at the Hospital for Sick Children and $12,500 to a project at the University of Western Ontario. We have $1 million for testing with respect to Red Cross. The central lab adds another $421,000. We have down here $130,000. The Provincial Advisory Committee on AIDS is $81,000, and there is $200,000 to the Ontario Public Education Panel on AIDS.

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Mr. D. S. Cooke: Just break it down in terms of public health education.

Hon. Mr. Elston: All this stuff is reasonably usable for education purposes. Every time you do something with research, you get more information. OPEPA is co-ordinating all the material. This is just what is done in Ontario. It does not deal with the important developments that are being done at the federal level through the centre for disease control in Ottawa.

Mr. D. S. Cooke: So this is all we need to do to.

Hon. Mr. Elston: No; it is not all we need to do. I have never said it is all we need to do, but I can tell you it is a far cry from your indication that we spend only $200,000.

Mr. D. S. Cooke: What should be done in the classrooms of Ontario? What is your recommendation of what the Ministry of Education should be doing in the educational system?

Hon. Mr. Elston: In terms of the work of the interministerial committee, I am not sure I have any particular information that may be useful to you. I do not know whether Dr. Blake is able to provide you with more information. We are providing the materials, the basis on which education programs can be provided. This does not mean that I have the authority–

Mr. D. S. Cooke: What is the leadership role in terms of telling boards of education what should be provided in their education system?

Hon. Mr. Elston: –to force a particular patient we deal with to do one particular item. Perhaps Dr. Blake could tell you a little bit more about the interministerial committee.

Dr. Blake: The interministerial committee, working in conjunction with the education panel, OPEPA, intends to provide curriculum material that can be used in the schools for grade 7, to start, and to work its way up. This project is just getting going.

Mr. D. S. Cooke: How long has the interministerial committee been set up?

Dr. Blake: A year and a bit. It was for exchange of information. It was not a working committee to produce information, because this was available from both the scientific advisory committee and from OPEPA.

Mr. D. S. Cooke: Does the interministerial committee have a mandate to pull together a total program of response to the AIDS virus?

Dr. Blake: Actually, we have asked each ministry to produce a strategic plan so they can be melded. They are just now coming in.

Mr. D. S. Cooke: What kinds of proposals are coming in from the Ministry of Education?

Dr. Blake: I do not recall what the Ministry of Education has in its proposal.

Mr. D. S. Cooke: What types of things are we looking at for use of the media, not just in terms of public service ads but also in terms of actually putting together a program similar to what they have in Britain to communicate facts about the virus?

Hon. Mr. Elston: Why are you so hung up on Britain?

Mr. D. S. Cooke: Because it is a good program and it has shown some leadership.

Hon. Mr. Elston: It is not doing anything more than what has been a very effective response at our end in the Ontario situation.

Mr. D. S. Cooke: Did you see the news story the other night about what happened in Kanata? Did you see the news clip about the car accident?

Hon. Mr. Elston: No, I did not see the news clip. I do not have a lot of time to watch television.

Mr. D. S. Cooke: One of the responses from the public health unit is that it has quarantined the truck and is going to burn it. That is the kind of understanding people have of the virus.

Hon. Mr. Elston: I do not think any of us has said there is no work to be done. The most important work to be done is having the information available to people and working with their medical officers of health and others. By going through the development of glitzy campaigns and all that sort of stuff, we do not necessarily get the same message out. Our people have done a very good job in liaising with the media, with working very closely through OPEPA to give the media the most up-to-date and recent information on AIDS. That is a very important function to play. When you ask us about what we are doing with the media, we have a very close working relationship, through OPEPA, with the media.

Mr. Andrewes: The manner in which the incident with the prostitute became public knowledge is rather interesting. I understand it was by way of police radio. They sent out messages to the officers in that precinct not to come in, because they had this woman in custody who claimed to have AIDS. They did not want the officers to become infected. Again, this points out a serious problem in educating people.

Hon. Mr. Elston: There is no question that there is more work to be done. However, we have had some very sensitive handling of communication of information through the medical officer of health. Dr. Macpherson, here in Toronto, has done a very good job, but it has been done on the basis of information developed both by the Provincial Advisory Committee on AIDS, the technical group, and by OPEPA, in conjunction with the people who are working at the federal level.

I found Dr. Gilmore and Dr. Clayton to be very knowledgeable, very helpful. In fact, theirs is a very close working relationship. I actually called a meeting here in December 1985 where we actually sat down with a very large group of people who were interested, including Dr. Gilmore and Dr. Clayton, and we had a lot of useful exchange of information.

I think the co-operative attitude among the provinces, with the help of the professional people at the federal level, has been one reason we have had a very good response in terms of the material we have developed. That is not to say that there are not areas where people have to receive more information. That is not to say that our central lab facilities do not have to be improved; in fact they do, and we are working on those. That is not to say that there cannot be improvements in getting the information through to other people. But we have a response and we have materials that are not only useful but are also accurate, and they are being updated as information is brought to us. From my standpoint, accurate information is one of the best tools with which to fight the virus.

Mr. Andrewes: What about these community-based groups?

Hon. Mr. Elston: They are recent, with the exception of the AIDS Committee of Toronto, which has been around, I guess, for a couple of years, maybe a little bit longer. I am not sure of the actual date, but we have funded them for two fiscal years.

There is a group in Windsor coming on line; there is a group in the Waterloo-Cambridge area.

Mr. Andrewes: Hamilton.

Hon. Mr. Elston: Hamilton has one. I think there are eight in total that have just really got started in terms of their organizing. We can take a look at what activities are going on with respect to the development of their status as corporations. Some of them have just come together and have not yet even received official status. We will take a look at what we can do to assist them, but at this stage it is a little early to understand what role they wish to play, how they want to carry out their mandate and whether we can co-ordinate it effectively on a provincial basis.

Mr. D. S. Cooke: Some of them have actually applied for funding.

Hon. Mr. Elston: Yes, I understand that, but that does not mean they have been existence for a long time. But I can tell you that when we have a chance to understand what they determine their role to be, we will take a look at what we can do with respect to using their facilities to assist us.

Mr. Chairman: Mr. Andrewes, anything further on the AIDS question?

Mr. D. S. Cooke: What is the other subject?

Mr. Chairman: The next subject I have that you were both interested in is the question of foreign medical students. Would you like to handle it next?

Mr. D. S. Cooke: Could we get the summary of the ministry's expenditures?

Mr. Chairman: On AIDS, the ones that were read a little while ago? Thank you. Send them through to me, I guess, and I will send them to the committee members.

Mr. D. S. Cooke: They are available now, are they not?

Mr. Chairman: They are in rough form, handwritten, at this stage. Now, the question of foreign medical students.

Hon. Mr. Elston: Before we go on, Mr. Chairman, I am just checking my information on the communities that do have committees: Toronto, Hamilton, Windsor, London, Thunder Bay, Kingston, Ottawa, Cambridge and Kitchener-Waterloo all have committees now, active in dealing with the question of AIDS. As I understand it, a number of these have actually applied to the federal government for funds. I am not sure how many have applied to us for funds, with the exception of ACT, which I know we are funding.

Interjection.

Hon. Mr. Elston: They have not yet got their charitable status; they do not yet have a charter, as I understand it, but they are working on those items.

Mr. D. S. Cooke: I had assumed they had their charitable status.

Mr. Chairman: Shall we move to the next subject, then? Medical students.

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Mr. Andrewes: There are really two issues here that I think the minister might give us some comment on briefly. One is foreign-trained doctors who find themselves in Canada either as immigrants or as refugees–and I do not know how you differentiate those–who have not been able to gain access to the necessary programs to requalify themselves. The second group, of course, are the Canadian-born students who have gone abroad for their training, who now find themselves, in some cases in the midst of their education, having to come back and requalify themselves as residents–that is, take up residency here for two years–go through the one-year screening process–

Hon. Mr. Elston: Clinical clerkship.

Mr. Andrewes: –and then hope to get in to one of the 24 annual positions.

Hon. Mr. Elston: In fact, I think it is reasonable to assume that if they have accomplished one of 24 positions for clinical clerkship, they have a very good chance of receiving one of the 24 internship positions, which are available exclusively to people who have just completed the graduate of foreign medical school clinical clerkship. That is a one-to-one ratio of positions.

Mr. Andrewes: All right, that is fair enough. The concern that is being expressed to me by a number of the parents of a number of those students, and by the students themselves, is that they entered the foreign medical school assuming they would be able to enter at least an unpaid internship program upon their graduation and qualify themselves to practise medicine here in Ontario.

There is that one group, but I think equally important is the other group, many of whom have now indicated their willingness to go and practise in underserviced areas. I have to accept that they are making that commitment seriously.

Hon. Mr. Elston: I do not doubt that it is a serious commitment.

Mr. Andrewes: Many of them are specialists and have talents that Mr. Pierce, and others yesterday, mentioned the need for.

Hon. Mr. Elston: Do you have a feeling for how many are specialists?

Mr. Andrewes: I have no idea, no.

Hon. Mr. Elston: Some are just graduates of medical schools without any practice whatsoever. I am not sure I know personally how many are specialists.

Mr. Andrewes: The only group I met with was a Polish group, and there were some within that group who were specialists, so I assume that some of the others are as well. It may be a wrong assumption.

I just find it a waste of talent. I do not mean to oversimplify this, particularly at a time when Mr. Pierce and others are raising with you the problems of medical talent in underserviced areas, it is unfortunate that we cannot use these talents.

Hon. Mr. Elston: It is interesting to note, I think though, that when we talk in most cases about the question Mr. Pierce has raised–and others, in fairness: Mr. Ramsay, Mr. Fontaine from my caucus, Mr. Foulds; anybody who is from northern Ontario–the question is more often about the availability of a specialist to deliver service, a surgeon or an anaesthetist for Atikokan, Elliot Lake or any number of other areas.

The fact of the matter is that we are answering that particular question with incentive funding and delivering a new program, the specialist incentive program, which will allow for travelling. That is one response to that.

The fact that we have approximately 600 graduates of foreign medical schools in Ontario now looking for positions to qualify for intern-

ships means that the question is one of a larger number of people–

Mr. Andrewes: How many?

Hon. Mr. Elston: About 600. That is a rough number around the province–our best guess.

Mr. D. S. Cooke: How many would be Canadians who might have gone to foreign schools?

Hon. Mr. Elston: I am not sure of the breakdown of those figures. I do know that the vast majority of those people would be–first of all, most of them now are Canadians, or at least landed immigrants. In terms of having gone back, as Canadians gone outside–

Mr. D. S. Cooke: You did not let me finish. I did not mean how many are Canadians who are coming or Canadians who have gone–

Hon. Mr. Elston: I understood that part of the question. The fact of the matter is that most of these people now are Canadians or at least landed immigrants, first and foremost. We establish that no matter what their status is, no matter whether they were trained first or whether they were here and then went back for training, they are citizens of this country, first and foremost.

As to the number, with respect to people who were born in Ontario or Canada, I think there are some 35 or 40 in the system now who have gone out; actually 40 Ontario citizens in Ireland, which would be basically Dublin. This would probably be the larger group. For instance, I had one person on Friday morning. I was at an event honouring the Treasurer (Mr. Nixon) for 25 years of invaluable service to the province of Ontario. I was there with 900 or so other people who were expressing best wishes. I know my two colleagues would have been there had they not been at other places.

In this case, a father of a student who now is completing school at the University of Punjab was indicating his desire to have his son admitted to a particular project. They had immigrated about 20 years ago when the son was two or three years of age. They likewise had gone to another medical school and gone out. However, the numbers, relatively speaking, of the people who have graduated from Ontario schools and then gone outside to nonaccredited schools is small. I do not think it would be out of line to say it is perhaps ten per cent. I am not sure that is accurate. I am only guessing. I do not really know.

Mr. D. S. Cooke: There are a fair number people down in Mexico.

Hon. Mr. Elston: Yes, a number go down there; Guadalajara. I am not sure how many, though, Mr. Cooke. I cannot be precise. I know of a couple of cases for sure. I know of the people who are going to Dublin and I know of the one case of the gentleman who has gone to India.

Mr. D. S. Cooke: Those are the only people who do not even qualify for your program when they come back.

Hon. Mr. Elston: They have to re-establish residency.

Mr. D. S. Cooke: For two years. I had a case in my riding office that I believe I have written to you about. His parents are Italian and he was accepted at medical school in Ontario, but he was also accepted in Rome and chose to go to Rome because his intention, when he came back to Canada, was to set up practice in Windsor and serve the Italian community. Now, of course, he finds out that it is all for nought because in all likelihood, with only 24 positions, and having to wait two years before you can have access to those, it is very unlikely he will ever be able to practise medicine in Canada.

Hon. Mr. Elston: I do not know that. I guess there are programs also available in other provinces. I can say that we have set aside these particular positions especially for people who have graduated from foreign medical schools. This was not done before. They are going to be funded. Most of the graduates of foreign medical schools qualified only for unfunded positions, as I think the tenor of Mr. Andrewes's question indicated.

The fact of the matter is that we have received a fair bit of pressure from the professional organization, the Professional Association of Interns and Residents of Ontario, which speaks on behalf of the interns and residents to eliminate the unpaid positions. We have received pressure–I did personally–from at least three groups that came to meet me, to remove those unpaid positions because the people felt they were taking unfair advantage of the people who graduated from foreign medical schools to begin with.

We have moved to do that. We made those positions available exclusively for graduates of foreign medical schools. I guess it is open for anyone to say it is not enough, but in doing so, I think a determination should be made by people who want to dispute the policy of what is an appropriate response in what is being suggested. That is our response and it is a reasonable response.

Mr. D. S. Cooke: You have done less than Quebec which is a smaller province.

Hon. Mr. Elston: I think Quebec has about 40 positions.

Mr. D. S. Cooke: They have an announced policy that provides for 90 rotating internships over 3 years.

Hon. Mr. Elston: It is 30 then.

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Mr. D. S. Cooke: It will get up to 90, though.

Hon. Mr. Elston: There are 30 in the system. Ours will end up having about 48 in the system. There are actually 72 including clinical clerkship, but in terms of interns alone there will be 48 paid internship positions in Ontario.

Mr. D. S. Cooke: We all see the difficulty. If you put 600 new doctors into the system, eventually it is going to cost I do not know how much.

Hon. Mr. Elston: It is not only that. From my standpoint, my obligation as Minister of Health is to make sure not that the 600 positions are added to the system but that those 600 positions are filled with qualified people who deliver quality service. First and foremost, that is my obligation.

Mr. D. S. Cooke: Obviously, they cannot get internships unless they have got into the system.

Hon. Mr. Elston: That is correct and that is the reason for the clinical clerkship. These graduates of foreign medical schools will go through the same sort of rigorous training in that fourth year that the graduates of our Ontario medical schools go through. I presume that is the same right across Canada in our accredited schools and is probably the same in other accredited schools. I am looking for help but I do not think we have anybody here who is really into that area.

Mr. D. S. Cooke: It would seem appropriate that there be some method. Although northern Ontario has the most acute problem, there are other areas of the province, such as Leamington which you are very much aware of.

Hon. Mr. Elston: It is interesting that you bring that one up because a couple of people have applied for those positions.

Mr. D. S. Cooke: The point is that there are shortages of doctors. There is a vast shortage of psychiatrists in my community. With the 24 positions, you are really saying that there is no way the majority of the 600 will ever get into the system. The numbers continue to grow each year, so something is desperately wrong at immigration. I can understand admitting the refugee doctor but I do not understand how people are coming into the country now and are still not being properly told by immigration that landed immigrants are not going to have an opportunity. Refugee doctors have a really good case for something extra special being done.

Hon. Mr. Elston: I understand your point. The fact of the matter is that it is my sense that if I added 600 positions tomorrow to deal with all the people in Ontario who are graduates of foreign medical schools, I would have another 600 the day after. It might not be quite that quickly, but it is a continuing problem, particularly when some individuals choose to send students to other medical schools for training in addition to the schools we fund and the resources we use to make sure our people receive high-quality training.

We have only so many resources with which to deliver that training. We have very intense competition for people getting into our medical schools in this province. All you need do is to ask some of the current people aspiring to places in medical school and you can understand the intensity with which the competition is undertaken, not only in medical school but also in dental school and others.

I remember my days almost 20 years ago when I went to the first years of university. I was in residence at the University of Western Ontario, a very fine and noble institution. In my early days on that campus, I discovered that some of the more senior students were busy scraping chalk and doing all those neat things they have to do to pass a test for dentistry school. The medical school aspirants were all burning the midnight oil and working very hard. That has not changed. There is intense competition. For some people who are not able to answer that, unlike your constituent who made the choice to go some place else, there is always the opportunity to try to go to a facility in another country. Some make that choice. Those people understand that they may not necessarily get into internship positions.

I think some people who immigrate here are given warnings that perhaps are not sufficiently heeded for one reason or another. They may not be delivered intensely enough. However, I think there is an attempt to have those people understand that it is not an easy road. That being said, I am not sure I am prepared philosophically to say to the federal government, "If a doctor applies to immigrate to Canada, say no."

Mr. D. S. Cooke: That is not what I said.

Hon. Mr. Elston: I understand that.

Mr. D. S. Cooke: There should be very clear messages about what the opportunities are.

Hon. Mr. Elston: I think they try to do that, but it is very difficult to have people acknowledge receiving information that it is a very difficult thing to get into medical practice and then ultimately say we cannot use their services when they have been trained to deliver children instead of pizzas, for instance.

Mr. Andrewes: What message was given to the Ontario resident who went abroad, that he would not get into an internship program?

Hon. Mr. Elston: As you understood and indicated in the question, they would probably have more access to unpaid positions. Those people have access to the 24 positions now set aside exclusively for graduates of foreign medical schools. Those positions, as funded positions, are more than what they had access to before in terms of receiving paid positions. From my standpoint, those people, as Canadian citizens, must be treated equally with people who are graduates of foreign medical schools who are landed immigrants or Canadian citizens. It should not matter to me whether they graduated before they came here and became citizens or whether they were citizens and determined to leave the province to get their education. There has to be an equality of competition among those people.

Mr. D. S. Cooke: The bottom line is you are not prepared to do anything more.

Hon. Mr. Elston: Are you making a suggestion that I do something in particular? I have a response now that indicates there will be 72 graduates of foreign medical schools in our system at any one time over that three-year period. It is always open for people to say, "That is not enough." I realize that, but perhaps you can tell me what you are suggesting I do.

Mr. D. S. Cooke: There are 24; next year there will be another 24 and another 24 and then the 72–

Hon. Mr. Elston: The only way there would not be 24 in the second and third year is if a person in a clinical clerkship did not meet the training criteria. I suspect there is going to be a very thorough screening of candidates who go in. The interviews are very intense. The applications, if I am not mistaken, are going out at the end of February, or that process will at least be started, so I am sure the interviews will pick the best candidates from among all those who apply. The only way you would not have 72 is if someone was unable to complete one of the years.

Mr. D. S. Cooke: There are still only 24 positions.

Hon. Mr. Elston: There are still 72 people working through our system.

Mr. Chairman: As a point of order from the chair to get your attention, we have an hour left before we start taking votes on this and we have five topics left. I need your guidance in terms of time. Do you want some more time? Mr. Pierce has indicated he would like to get involved in this issue. Is there anything further from you on this, Mr. Cooke?

Mr. Pierce: I have a further question on the availability of doctors. I do not want the minister to leave with the impression that the need for doctors in northern Ontario is only for specialists.

Hon. Mr. Elston: Where did I say that?

Mr. Pierce: Each year the different hospital organizations travel to eastern Ontario to the universities to try to attract doctors of any kind to northern Ontario. There is a shortage of general practitioners as well as specialists throughout the north. It costs those individual hospitals a fair amount of money to go on that tour, some with success and others without any success.

Hon. Mr. Elston: In fact, the ministry assists those people on those tours. I think about the week of October 20 this year was the time when people from northern Ontario and underserviced areas were hosted on that tour by the underserviced areas program people.

Mr. Pierce: I think it is about the time they are writing exams in October. It is very difficult to–

Hon. Mr. Elston: The tour is done here through the facilities sponsored by us for northern members of the hospital boards of northern facilities to come to the institutions here.

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Mr. Pierce: They all come down with their paraphernalia, with pictures of their clinics, hospitals and communities and try to sell their communities to doctors to encourage them to move north. Maybe somewhere within the ministry we should be looking at facilitating already trained doctors who are available and have indicated their willingness to go into those areas and service them. How do you do that?

Hon. Mr. Elston: We do if they want to sign up for our underserviced areas program and it will provide $40,000–

Mr. Pierce: I am talking about the people who–

Hon. Mr. Elston: –do not have licences yet.

Mr. Pierce: That is right.

Mr. D. S. Cooke: Just like Sheila Copps used to say when she was the Liberal Health critic.

Hon. Mr. Elston: Sheila raised an incredible endeavour of very intriguing ideas in the health care system and has made a very reasonable and rational contribution to the deliberation of these policy items.

We will continue to assist people who are willing to come. If psychiatrists are raised as an issue of undersupply, which they have been on occasion, we do recruit from other jurisdictions those people who are in short supply in Ontario. A number of psychiatrists have been recruited from other areas, including Britain. Sudbury is a good example of someone being recruited from Britain to develop the oncology program there. We do this when we find there is a shortage of supply of those people here and we will continue to do it. The point I think the honourable gentleman is making, however, is that he would like to see more–

Mr. Pierce: The terrible challenge is that there is nothing within the Ministry of Health that indicates you are going to look at existing doctors who are not licensed to practise in the province.

Hon. Mr. Elston: That is right.

Mr. Pierce: They are still going to wash cars and work at McDonald's.

Hon. Mr. Elston: From my standpoint, there has to be a way of assessing the ability of those people to deliver quality service to the people of the province. With respect to someone who is delivering an oncology program in Sudbury, for instance, or people who are psychiatrists who may have been recruited from other jurisdictions, they are able to come here and receive licence or exemption from going through the licence requirements because their experience has been judged by the College of Physicians and Surgeons of Ontario as being an appropriate substitute for any length of internship or residency here in Ontario. I think I still have to honour that in terms of being assured that somebody has provided a standard, has taken a look at the credentials of the person to provide that quality medical service. Any time someone wants to come, he can always apply for an exemption at the college.

Mr. Chairman: Before we move on to the next subject, perhaps other members of the committee noticed the incredible scheduling of Dr. Psutka's allies flying by in the emergency helicopter. I think he must have said he was likely to be on today, to provide this intervention. Even though he is not in charge of palliative care, that is the next subject you were wanting to raise.

Mr. Andrewes: He flies by my apartment every night and it is hard to get to sleep.

Perhaps it is Mr. Cooke's turn.

Mr. Chairman: All right. Do you want me to talk about health discipline review?

Mr. D. S. Cooke: I would like to talk about Caressant Care, the Tavistock-Woodstock situation and St. Thomas. The minister will know that these are the homes where Caressant Care has bought other homes and has forced the relocation of nursing home residents. I gather that in the St. Thomas one, discussions are taking place with your ministry and that the moving of the residents has not taken place yet. I am not sure whether the Tavistock residents have been moved yet. I would like to know what the status is, what your feeling is and what the ministry is going to do. Are you going to approve the moving of these residents?

Hon. Mr. Elston: There are two different items in that. We dealt with one partially when we were talking earlier. Some of my comments might be applied to this issue in a like manner as those that were applied to Mr. Pollock's question on Norwood and Tweed.

There are two different issues in two different locales. In St. Thomas, the movement of accommodations is within the municipality. I have a letter from a resident of St. Thomas who had a member of the family in the rest home part of the to-be-renovated facility who was very much in favour of seeing the renovation occur, of having the rest home residents in one facility and the nursing home residents in another.

Mr. D. S. Cooke: Let us not give the impression that the residents or the families are all in favour.

Hon. Mr. Elston: Members of city council were consulted. Not all are in favour of what is happening. From my standpoint, the question of moving the community facility away from the community is not present as it is in Tavistock.

Mr. D. S. Cooke: There are statistics on the effects on residents of forced relocation, whether within the same community or not, and studies have been done on the negative effects on health. Some of those studies indicate significant increases in the numbers of deaths of residents months after their forced relocation.

Hon. Mr. Elston: I am not sure whether Ron Sapsford, who is the director of the nursing homes branch, has that information at the tip of

his tongue, but let me respond in this manner to that issue. It is my opinion that we should be looking at using extended care beds as much as possible for the temporary location of people and not as the final destination for our seniors. I hope we will be able to develop appropriate activation programs that will allow people to move into the facilities and out of them. That is a direction in which we would like to go.

Mr. D. S. Cooke: We all agree with that. That is not happening.

Hon. Mr. Elston: It is not what is happening, but it is not uncommon to have people move from one facility to another when they have been placed in one for recuperation and another bed becomes available in a community closer to home.

I have that in my own area, where the waiting time for beds is sometimes lengthy. We have three facilities within about 15 miles of the Wingham and District Hospital: Brussels, Wingham and Lucknow. These are used one substituting for the other, and people are moved.

Ron may have some helpful information on the statistics.

Mr. D. S. Cooke: There are some other aspects that need to be addressed. Why were these sales approved, with the implication of relocation, without the residents, their family members, the staff or the unions being consulted?

Hon. Mr. Elston: I am not sure of the circumstances with respect to St. Thomas. Ron, do you have any information on the Caressant purchase in St. Thomas? Then we will move on to Tavistock.

Mr. D. S. Cooke: I spoke to them as late as today and they were not consulted ahead of time.

Mr. Sapsford: No, I believe that is the case. The proposal for the sale was brought by the owner. The original home had been sold several times in the past four or five years. The owner at that time approached the ministry with the proposed purchaser, being Caressant Care. Part of the sale proposal did involve the relocation within the St. Thomas area and the consolidation of the beds.

Mr. D. S. Cooke: Then the question is a policy question to the minister. Those being the facts, why were the residents, the family members and the employees not even consulted when the implications were clear that it meant forced relocation and job loss?

Hon. Mr. Elston: I cannot answer that. It is a question of policy, though, which we can consider on our own. Whenever new facilities are being built there will be relocation, and I expect that over the next while the renewal of some of the capital structure will require people to be moved. That is not a satisfactory answer in the case of St. Thomas, but I expect that when people know a new facility is to be built there will be a great deal of interest on the part of relatives and on the part of the residents themselves in seeing those new facilities being provided.

Mr. D. S. Cooke: Yes, but that is not the problem in this case.

Hon. Mr. Elston: No, I understand, but there is a desire to reconstruct or to provide new facilities in St. Thomas. That is the reason these places or beds are going to be moved from one to the other.

Mr. D. S. Cooke: They are going to be handed on to Caressant Care.

Hon. Mr. Elston: Yes, the new facilities.

Mr. D. S. Cooke: They will then convert Rest Haven, which already exists, totally to a rest home.

Hon. Mr. Elston: I take your point. I am not arguing about advising residents or families. I am not going to debate that question with you. It is something I have to consider in terms of a policy question.

Mr. D. S. Cooke: Are there not provisions to correct this problem in the amendments to the Nursing Homes Act?

Hon. Mr. Elston: You can sometimes deal with concerns via regulation. You do not have to have everything in the legislation. However, it is a policy matter about which I think guidelines can be established. It is something we can consider. I am not going to debate the relative merits.

1710

Mr. D. S. Cooke: Are we saying in this case that since the sale was approved based on relocation of the residents, there is nothing the ministry can do at this point in the Rest Haven case to prevent the eventual moving of the residents to the Caressant Care facility? Is that the bottom line in St. Thomas?

Hon. Mr. Elston: My advice is that they are making plans to build new facilities and to have the facilities in Rest Haven become those of rest home residents only and not nursing home. If you are suggesting they not move at all out of facilities which are not in compliance, that becomes a different question for me.

Mr. D. S. Cooke: I am not sure whether the issue is totally that Rest Haven home is in compliance. The home has been asking for additional numbers of beds over the years, which I have not supported.

Hon. Mr. Elston: You raised Rest Haven in the Legislature in 1983 or 1984, as I recall.

Mr. D. S. Cooke: I do not believe I raised Rest Haven. I think I talked about a home in Aylmer.

Hon. Mr. Elston: I think there was one in St. Thomas too. I will check my correspondence.

Mr. D. S. Cooke: You can check, but I think it was the one in Aylmer because I remember very clearly going up to that home.

In any case, this home has 50 beds. I remember meeting with the union at Rest Haven. I know they have the 50 beds and the Ontario Nursing Home Association says that 60 makes a nursing home economically viable. None the less, your ministry approved the sale with the forced relocation and I want to know what the bottom line is.

Is the bottom line that there is nothing you can do to prevent this relocation now, that it is going ahead, and that the meetings taking place between the employees and other people concerned with the director of the nursing homes branch are futile? What is the purpose of these meetings taking place in St. Thomas if the forced relocation is the bottom line?

Hon. Mr. Elston: I do not know about the meetings. Perhaps Ron could tell us about the meetings and what they are designed to accomplish.

Mr. Sapsford: I met with the president of the auxiliary of the nursing home last week in London. Their having requested a meeting, the purpose was to find out their concerns. The concerns of the residents were expressed through the auxiliary member. My purpose in meeting was to find out, in the event of the move, if there were ways in which the residents' needs would be taken care of.

They had made reference to married couples in the facility and that relocation would required that they be split apart. There were ways we could work with the operator to make sure those kinds of situations did not arise.

There was a member of the staff at the home there as well who was expressing concern that they did not know about the details of the move. The owner had not met with them.

Mr. D. S. Cooke: They also pointed out that residents would move from one home to go to a home without the same staff.

Mr. Sapsford: That was one of the concerns they pointed out.

Mr. D. S. Cooke: Caressant Care is hiring part-time staff.

Mr. Sapsford: Right. I was there primarily to gather this kind of information so these kinds of concerns could be brought to the attention of the nursing home. Our concern in watching that kind of situation is that, wherever possible, we can negotiate conditions with the operator that would make that kind of transition easier and could satisfy the needs.

Mr. D. S. Cooke: The bottom line is that the relocation is going to happen. There is nothing that can prevent it.

Mr. Sapsford: In my mind, correct. The question about notice and advice and so on as in the regulation, requires that on the closure of a nursing home–which is what this would be–eight weeks' notice be given.

Mr. D. S. Cooke: Less time than a tenant in an apartment building gets from a landlord.

Hon. Mr. Elston: If it is a yearly lease. Is that right?

Mr. D. S. Cooke: No, the period required is 90 days or 120 days; one or the other.

Hon. Mr. Elston: Up to six months if it is a yearly tenancy on the basis of a contract, I guess.

Mr. D. S. Cooke: If, for instance, it is at the end of the lease or if there is no lease, more notice is required to be given to a tenant.

Hon. Mr. Elston: This is going to be well in excess of that, in any event.

Mr. Sapsford: The reconstruction is scheduled for next fall, so there is much more than the regulatory requirements. On the the other point, on the literature regarding the location, most of the literature that has been done has been on the basis of people who have been relocated on 24 hours' notice. In other words, you are in this facility today and you are leaving tomorrow.

These kinds of situations, where homes are closed and rebuilt and people moved, are based on a much longer time frame, so residents, family and staff have an opportunity to plan for those kinds of relocations. Even in the literature, there is conflicting evidence. In some studies, relocation is not shown in the research to be contributory to death rates and so on.

Mr. D. S. Cooke: It is not particularly fair if residents are moved and there is no consultation whatsoever. It boils down to policy being that when you buy a nursing home, you buy people and move them, whether it is the same thing that

happened in Ridgetown with the Barnwell home, this facility or the Tavistock one. When you buy a home, you buy people, because the people represent the cash flow. That is bloody unacceptable.

Hon. Mr. Elston: If that is the way you like to characterize it, I appreciate that.

Mr. D. S. Cooke: That is exactly how your party characterized it when you were in opposition and Mr. McGuigan raised the matter of Barnwell in Ridgetown. There is no other way of characterizing it.

Hon. Mr. Elston: I have already indicated what my reading of bed allocations is–that is, they are a community resource–and from my standpoint, that is where it stays.

Mr. D. S. Cooke: What about Tavistock and Woodstock?

Hon. Mr. Elston: Let me talk to you a little about Tavistock, because it has a difference that is not present in St. Thomas–that is, the movement of people from one community to another–which causes some difficulty. I think there are 43 beds at the Maples Home for Seniors. Some of those people may very well be from the Woodstock area. I am not sure. Some are from the Waterloo area, to which we have allocated some new beds. Some people may make a decision to move back to their own community. I have not yet met with the residents' representatives or the community representatives. I will be doing that before any decision is made, so there has not been a final decision in that case.

Mr. D. S. Cooke: When do you expect a final decision?

Hon. Mr. Elston: I have not had the meeting. I indicated to the community group that a decision would not be forthcoming until I met with them, and I have not set the meeting yet.

Mr. D. S. Cooke: I hope you will look at the other aspect of talking to the residents. If you follow the philosophy that it is their home, then they have a right to be talked to.

Hon. Mr. Elston: That is right in terms of communications; I think it is always important in this issue, as in any other. The question of whether people should be able to build facilities that deliver a better service or assist the staff to deliver better service is, in my mind, a matter about which there should be notice, obviously, but if you are going to provide the better service, I do not think you should hold up an entire project in an area that is not in compliance.

Mr. D. S. Cooke: There is more to working it out than just that. It is not always a question that it is a new facility. Caressant Care does not exactly have a clean record in St. Thomas, and there is not unanimous agreement that the service is being broadened.

Hon. Mr. Elston: I have discovered that in health care there is never unanimous agreement. The fact of the matter is there are sometimes benefits received from the design and building of new structures.

Mr. D. S. Cooke: No matter whether Toronto is going to decide on those benefits or whether the people in the community should decide?

Hon. Mr. Elston: There is the question of benefits not only to the residents but also to the people delivering service there. As much as possible, I would like to see facilities that would help staff in the nursing homes be able to provide service in a very reasonable way without endangering their physical health. We do have questions where facilities have stairways and things that require lifting and the type of work that causes difficulty for the people who deliver service.

All I am saying is we always have to make ourselves aware of the benefits available in the development of new facilities, both from the standpoint of the patient and from the standpoint of those people delivering the service. If people are able to deliver the service efficiently in a healthy manner, then I think you will get better service delivered and you will have a better atmosphere for the people who live in it. I take your point with respect to communications.

1720

Mr. D. S. Cooke: We will have some amendments for your nursing home legislation that will assist in giving some rights. Instead of people in Toronto making a decision of what is best for people in St. Thomas, perhaps the people in St. Thomas and the residents should be able to have some input into what affects them.

Hon. Mr. Elston: In fairness, that is not exactly what happens in all cases. We have a number of people with whom we consult, in some cases, as we have with respect to the district health council in the Thames Valley. They have given us an opinion with respect to the nursing home beds in Tavistock.

It seems to me there is a community effort involved with respect to these facilities which has to be co-ordinated with people who are operating the facility as well as those people who have a responsibility to inspect and monitor and man-

age, which is being done at the provincial level. I think it is a melding of those. It is not exclusively any one of those groups.

Mr. Chairman: Given the time, maybe we should move on to another item. Mr. Andrewes, which would you like? You have palliative care and you have several questions on abortion?

Mr. Andrewes: Palliative care will be very brief. In our travels around on the task force, we had a number of presentations from very sincere and supportive people. One common theme was that there needed to be some guidelines developed in palliative care that would provide community hospitals, for instance, with a set of criteria they could build on in order to meet expectations. I leave that one with you.

The other issue, of course, is the old issue of funding and whether or not palliative care is looked at as a form of health care delivery that warrants some special recognition, particularly in hospital budgets, over and above what is left over in the global budget.

Hon. Mr. Elston: To address the first item, I was just getting the location of the two programs that we do fund for palliative care. One is in the Elisabeth Bruyère Health Centre, where I have toured and been with the physician in charge and a number of the staff people there.

I was very much taken by the delivery of care there, provided in a very sensitive way not only to the patient but also to the family, and it seems to me those people have really developed a good program in-house, as it were, inside that medical facility, but they have also recognized a need to reach out into the community and they have developed some components of a community service as well.

I am not as familiar with the second program we fund, which is at the Salvation Army Grace Hospital here in Toronto, but it seems to me that in developing the guidelines that may come along we have to recognize with respect to palliative care, first of all, that it is part of a continuum of care, not only for the patient but also for the family members and friends, and we also have to recognize that it is not just for the hospitals or any other facility in which people pass through in this life.

We have to recognize that we probably cannot rely exclusively on volunteers in any one sector to keep delivering the services in the smaller communities where these ad hoc programs develop basically around people who have gone through an experience in their own families and as a result develop their own programs. We have to have guidelines.

Mr. Andrewes: They can play a major role though.

Hon. Mr. Elston: Yes, but we cannot rely solely on them. We have to be aware that it is the volunteers—as in other sectors of hospital care, for instance, or even in some of the community responses to problems—who make the program much more enhanced.

We have to develop programs which will allow us standards inside institutions and in the communities. I am not pleased to say that right now the only programs we fund are the two I noted. Those have been very good ones, but we have a lot of work to do in smaller communities.

I have been taken by the work of Connie Osborne in Huron county. She is from Goderich and has worked for a number of years in palliative care as a volunteer in the Alexandra Marine and General Hospital in Goderich. The work has been quite exciting for her. As her expertise has developed as a volunteer, she has gone from a stage where no one wanted to refer anybody, to where everybody would like to use her abilities to assist them in dealing with a part of delivery of care to a patient with which physicians are not well conversant or to which others in health care are not well in tune.

There is recognition that it is increasingly a part of health care, and that is leading us to do more work in developing our proposals with respect to palliative care. We are doing it on the basis that we recognize there will be a difference in delivering it in a larger centre from delivering it in the smaller communities such as those from which you or I come, Mr. Andrewes.

Mr. Andrewes: I have made the point. You recognize there is an anxious group of volunteers who are looking to government for some signs of leadership, both in tangible financial support and in direction. They are doing some very good work.

Hon. Mr. Elston: Without doubt. However, if we develop funded programs, we have to make sure that we have some indication of the provision of the service in—I hate to say "a standard manner," but at least in a manner which measures up to a standard, so that we are sure of what is being delivered as a program throughout the province. I recognize your thoughts.

Mr. Andrewes: Thank you.

Mr. D. S. Cooke: I would like an update from the minister on the assistive devices program and where the phase-in of coverage is now. I would like a general answer, but I would also like a specific answer.

In a letter you wrote me on August 21, 1986, you indicated that at that time oxygen and oxygen equipment were not covered but would be covered shortly. My understanding is that as of December, when we started estimates, it still was not covered.

Hon. Mr. Elston: There are some areas in which the respiratory assistance is covered and some areas where it is not. We also include oxygen under the Ontario drug benefit plan. That part of our ODB plan has been quite active, as the assistant deputy minister in charge of the program would want to underscore.

My reply was in August, so we would have told you about the addition on July 1 of the prosthetics, which would include limbs, breast prostheses, eyes and things such as that. On September 1, respiratory equipment and supplies to all ages were included.

With respect to some oxygen supplies, those have been left with the Ontario drug benefit plan. I am not sure I can tell you under what circumstances those policy decisions are made. Perhaps Dr. Psutka could tell us when the oxygen is supplied under ODB and when it would be considered under the assistive devices program.

1730

Mr. D. S. Cooke: Obviously, ODB does not cover a fair number of people.

Hon. Mr. Elston: Yes, ODB may not cover some people if they are not involved in a disability program.

Mr. D. S. Cooke: Or their spouses.

Dr. Psutka: The respiratory equipment is now covered. Devices which deliver the oxygen, such as nebulizers, humidifiers and various other mechanical devices, are now covered for everyone. The gases themselves have not been included at this point. They are coming up though; the exact implementation date is coming forward to the minister in the next few weeks. We have gone through the remainder of the program to be implemented and have a series of dates we will present to the minister. I cannot give you dates yet.

Mr. D. S. Cooke: What is the rationale for covering oxygen equipment but not oxygen?

Dr. Psutka: The equipment itself is the product we felt was in greater demand. They are not all oxygen devices which deliver oxygen. Some are for nebulization and some are for humidification and that type of thing. The oxygen is available through the Ontario drug benefit plan as stated. When the total program is finalized, it will all be included under ODB.

Mr. D. S. Cooke: I am curious to know why oxygen equipment was covered. I understand there is more to this than just oxygen, but I do not understand why you would supply oxygen equipment but not oxygen.

Dr. Psutka: There are a lot of reasons. The foremost is that we are working to develop guidelines to ensure that the oxygen is given and dispensed appropriately. If you look at the literature right now, one dilemma is that the supply and dispensing of oxygen is coming under scrutiny in many other areas to ensure that it gets to the appropriate people. It can become a very expensive program.

Mr. D. S. Cooke: What about the total picture? Is it easy to give me an answer about what is not covered at this point or is it so extensive–

Dr. Psutka: Do you mean as far as what is not covered?

Mr. D. S. Cooke: For whom? What is still not covered for people over 22?

Hon. Mr. Elston: Ostomy supplies, medical gases, wheelchairs and mobility devices, hearing aids and incontinent supplies.

Mr. G. I. Miller: What about limbs?

Hon. Mr. Elston: Prosthetics were covered as of July 1, for all ages.

Mr. D. S. Cooke: Do you expect the phase-in to be completed some time in the next fiscal year?

Hon. Mr. Elston: I do not have the dates recommended, but I am looking at making a considerable dent in them during this fiscal year. There are some problems in terms of phase-in which I became aware of when I became minister. It required substantial lead time in making sure we had the support services available to deliver the programs. Therefore, I now expect to receive recommendations from the program people as to when they can meet the targets of having the support services in place for those devices. On the basis of that, we will make recommendations as to the startup of those programs.

Mr. D. S. Cooke: I am sure we do not need to request a copy of the dates when you see them because I am sure there will be a press release.

Hon. Mr. Elston: Probably not when I see them. Once we make some determinations and find out what our budget tells us–

Mr. Andrewes: I thought you were going to provide a copy of the speech by the Premier (Mr. Peterson) when he was not the Premier, who was going to phase in immediate implementation.

Mr. D. S. Cooke: Yes. He promised the phase-in would be all at once. The promise was made in the 1985 election when the Premier was filling out the questionnaire for the Ontario March of Dimes.

Hon. Mr. Elston: We have done a considerable amount of work towards developing the program.

Mr. D. S. Cooke: It is not in line with what the Premier promised.

Hon. Mr. Elston: It has been an interesting program to administer and develop the guidelines for, to make sure we deliver efficient programs. The Premier has been very supportive. He has been encouraging us to move forward as quickly as we can.

Mr. D. S. Cooke: It is too bad he did not deliver what he promised.

Hon. Mr. Elston: The entire program will be delivered without doubt in a manner which will be acceptable, not only to the Premier, but also to the member of your caucus.

Mr. D. S. Cooke: Two years after he promised it.

Hon. Mr. Elston: You will be very happy to know that the wrinkles that had not been solved when I came here are slowly being eliminated and the smooth introduction of the programs will probably occur in due course.

Mr. Chairman: Murray's ironing board, it is called.

Mr. D. S. Cooke: This means the next minister is going to be able to make the announcement.

Hon. Mr. Elston: The gentleman reflects and speculates a bit, but I thought that speculation was more a part of the Tory philosophy than that of the New Democratic Party. I am not able to prevent the honourable gentleman from getting into speculation. That may be a new departure.

Mr. Andrewes: I specifically asked the minister to comment on the story that, during the whole ruckus around Bill 94, Women's College Hospital was asked to assist in the backlog of abortions and was offered financial incentives to do that.

Hon. Mr. Elston: It is my understanding that those discussions were had by members of my ministry and that a number of discussions were entered into with respect to the question of access. It has been an ongoing study. Any discussions that were held were designed to find out what could be accomplished to provide better access, if that was required. That being the case I am sure Dr. Powell, who is busy developing a report for us on access, had discussions with any number of people on this issue. Since I was not involved, it is very difficult to comment on what was said or what was not said at any meeting.

When Dr. Powell is going through her study, I expect she will have very frank and open discussions with members of her profession, the medical community, about what is possible. I expect she will have a full and frank discussion with people who operate various hospitals, probably not just the people at Women's College but right across the province, and I expect it will be worth while for us to deliberate upon the result.

I do not think it would be productive for us to speculate on what occurred or did not occur. All I can tell you is that during the discussions that surrounded the Health Care Accessibility Act and its ultimate passage, we were able to provide a level of service in the province that was not severely damaged by the work action. There was no question of inconveniences. There were questions of some elements of the medical community wishing to withdraw their service, but that did not occur.

We are now looking at any number of options that might be appropriate for us. As soon as we get the report from Dr. Powell, we will be able to see the options that might be used to address the major concerns her report raises with us. I do not expect that we anticipate having only one facility pick up the backlog or anything in particular. A community, provincial response to this issue is required.

Mr. Andrewes: You have anticipated my second question. That is the real key. We have discussed in question period and on other occasions whether we have a law that we must work with.

Hon. Mr. Elston: There is no question. We must work with the law.

Mr. Andrewes: In a province where the geography is very complicated, where the population distribution is certainly very complicated, women of this province who may wish to exercise their rights under that law may not be able to access their rights equally under the law.

Hon. Mr. Elston: If that is the question, then Dr. Powell will report to us on that and tell us what she has found. We will go from there.

Mr. Andrewes: When do you expect her report?

Hon. Mr. Elston: I expect it very shortly. I think we are within a couple of weeks of

receiving material. I have not talked to her about it, but it is my anticipation that it is nearing completion, and I expect to talk to her shortly.

Mr. Andrewes: How many hospitals in the province now have operative therapeutic abortion committees?

1740

Hon. Mr. Elston: I do not know. I do not think we have those data offhand. I can write you on it and let you know what I find.

Mr. Andrewes: If you are going to do that, I would like some idea of the distribution.

Hon. Mr. Elston: We will do the best we can, although we do not generally go place by place. The information would be available if you contacted each hospital to find out what was done, but I do not think we necessarily have that. We would have to do it on our own.

Mr. Andrewes: Are any of the therapeutic abortion committees that were disbanded during the–

Hon. Mr. Elston: They are all back in place.

Mr. Andrewes: They are all operable now?

Hon. Mr. Elston: The only ones that were talked about were the ones in Sarnia, which came back quite quickly afterwards, and in Mississauga, which I understand is also functioning. Those are functioning.

Mr. Andrewes: I would be very interested in seeing Dr. Powell's report. I hope that will provide an important step in trying to–

Hon. Mr. Elston: She is doing some very important work and I will be sharing that, with the province actually but certainly with my Health critics.

Mr. Andrewes: Thank you.

Hon. Mr. Elston: I know you are in need of extra reading.

Mr. D. S. Cooke: I have just one question. I would like to get an idea of where we are with the health disciplines review and what your timetable looks like.

Hon. Mr. Elston: The discipline health professions legislative review is into phase 2, and we are dealing with all the 25 groups that have been designated for regulation. Also included in that are all the groups that participated in the initial phases. We have not excluded notice to any of the groups that may want to participate in the deliberations. However, from the standpoint of the 25 professions that are designated for continuing regulation under the act, they have a lot of work to do in defining scopes of practice and otherwise.

With respect to one, midwifery, there is a particular task force now on the road dealing with submissions from the public. It has done some travelling in North America and in Europe into areas that have already established them. It will be reporting some time in March or April, in spring anyway. I am not sure of its timetable.

I am meeting with the members of the task force in the next couple of weeks to get an update on where they are in terms of their deliberations, where they have been and what that has provided for them in terms of questions they must address or how they are going to address them.

We will have–I am guessing again, but I suspect we will have–a draft piece of legislation which will probably come to me later in the fall for review, and then we will proceed from there. That is the best I can say.

Mr. D. S. Cooke: Realistically, we are talking about an introduction into the House at least a year from now.

Hon. Mr. Elston: Probably; that is not unrealistic. The key to the quickness of this thing moving is how many areas within the review, the questions of scope of practice, cause difficulties. The professions will have to meet some type of an agreement with respect to where their scope goes and where others go.

We are into some very intense times right now. A lot of work is being done by Alan Schwartz and the review team. I am quite impressed with the work of Mary Eberts, Karyn Kaufman, Rachel Edney and Alan Schwartz on the midwifery side of it. Mary Eberts, who is chairing it, Karyn Kaufman–who, by the way, was voted one of the high-profile citizens of the year in Hamilton; I noticed that in the New Year's eve edition of the great Hamilton Spectator–and Rachel Edney have been very encouraging. They have been very thorough and have done a whole lot of extra work. In fact, from the standpoint of a lawyer, a nurse and a physician, they have learned a great deal about the manner in which midwifery has been–

Mr. D. S. Cooke: Are you going to re-examine at all, the exclusion of naturopaths?

Hon. Mr. Elston: We announced in April of this past year that they were not to be regulated.

Mr. D. S. Cooke: That was a statement by Mr. Schwartz.

Hon. Mr. Elston: It was my statement as well.

Mr. D. S. Cooke: That was your own policy?

Hon. Mr. Elston: Yes. I had indicated in the announcement of the 25 professions to be regulated that naturopaths would not be one of them.

Mr. D. S. Cooke: There is no consideration being given to that?

Hon. Mr. Elston: We went over a very thorough analysis of criteria. We measured each organization on the basis of those criteria and we have continued to live by the criteria we set. I do not think reopening the review now to establish other criteria that would allow one organization or another to qualify would be a relevant procedure. It certainly would not be fair to the others.

Mr. D. S. Cooke: It might end up happening in the legislative committee anyway.

Hon. Mr. Elston: Anything is possible.

Mr. Andrewes: What criteria did you use?

Hon. Mr. Elston: There were nine criteria, none of which I have my hand on at the moment. However, I can provide them to you.

Mr. Andrewes: I wonder which–

Hon. Mr. Elston: Just a moment so I can finish where I am going and then I will get back to that and you can ask your question.

With respect to the naturopaths and with respect to other organizations that did not meet the criteria we established and the tests we used, it has been made quite clear to them that the type of legislation contemplated would be of a nature such that any organization can apply when it feels it has met the tests established for all the organizations that have been involved in this review.

It will not be the type of legislation, if the material goes through the Legislature in the manner I hope it will, that will prevent us from amending legislation with respect to one profession until we can get an agreement from all professions not to do whatever each has under its own hat.

We will be looking at sections that probably deal exclusively with midwifery, and if midwifery needs some amending at a later date, we can deal with it. As the member for Lincoln (Mr. Andrewes) will be aware, when we dealt with the question of amending the College of Nurses requirements, we had to wait an appropriate time until we could isolate that single issue, which we did by agreement last year when we expanded the College of Nurses to get extra people.

That being the case, we would be in a position to have people come back to us, naturopaths or whoever, as they matured as a profession and as they developed the public interest aspects we require of the professions, and say, "We wish to be regulated." We would then be able to run them through a series of the same tests that will apply to the other 25 organizations, and they might very well be able to have a section added to the health professions legislation review.

Under that aspect, we will review again and again the various positions of professions that have been indicated or have been told they will not be part of the regulated group. For instance, we have the radiologists' assistants, or whatever they are called, medical assistants of some sort, who were excluded. The same would apply to them when they are writing letters. Acupuncturists have also been excluded. They are writing and the same would apply to them.

Any organization that has been excluded will not be excluded for 60 years, or, as in the past case, when the most recent amendments were in 1974 or 1975. That means we will be reviewing on an ongoing basis, but the developments that are going on now just apply to the 25 organizations.

I was going to forget that if I had let you intervene.

Mr. Cordiano: I have a question–

The Vice-Chairman: Is this a supplementary? Can I clarify, Mr. Cordiano? Is this a new question?

Mr. Cordiano: Yes.

The Vice-Chairman: I will bear that in mind. We will finish up with this question.

Mr. Andrewes: On which criteria did the naturopaths fail?

Hon. Mr. Elston: There were a couple that caused us problems in terms of numbers. We know the largest number of naturopaths are dual registrants, as chiropractors and as naturopaths. They can be or were included in both boards. Some confusion has been caused by the question of numbers, by the question of their willingness to bear the cost of the public interest organization and by the question of their willingness and the manner in which they are able to provide the public interest, as opposed to the interest of the organization, as a salient feature of their regulation.

The public interest has to be a salient feature of any group that is involved in self-regulation to any degree. There are other areas that cause problems, and I think I have written you a note on some of these areas; maybe not you. I have written to almost every other member. I will

provide you with the criteria and the manner in which those tests were applied.

1750

Mr. D. S. Cooke: All I can hope is that one leader has had a portfolio shift before we deal with the health disciplines legislation.

Hon. Mr. Elston: Mr. Cooke is expressing a sentiment that is a bit difficult from my standpoint. It is complicated; it is complex. When we went into phase 2 of the question of scopes of practice, we had already received some 7,000 pages of material. That had not just been received by the Schwartz team; it was received and then redistributed, one group's material to everybody else.

Mr. D. S. Cooke: That is why I think this process is a better one than if you were doing your draft bill next fall and eventually coming with a final bill in the spring, expecting that the Legislature is going to lock in the position.

Hon. Mr. Elston: I do not mind the situation that only four people will be subject to very in-depth briefings about what is going on. For us to indicate that a group of legislators could spend the amount of time that has been devoted to this exclusively and come up with a product in nearly the same time frame would be impossible to conceive.

Mr. D. S. Cooke: There will be no leadership conventions to interrupt, or likely none, as there have been with the current committee.

Hon. Mr. Elston: If there are leadership conventions involved, I am sure that all of us as political observers will be quite interested in them. For those members of the official opposition who even now are putting in place their junior forms of campaign teams, there would be increasingly more interest than for others of us. The review will go on and proceed to a logical and helpful conclusion for the people involved in health professions.

Mr. D. S. Cooke: It will only be beginning for the members of the Legislature a year from now.

Hon. Mr. Elston: That is what the process is all about. We have to have a lot of assistance to help us to receive, digest and then re-examine the material that is brought forward to us. The nice thing about legislative government is that we have committees at which people have another time to make their case and present it. In fact, with respect to the pharmacy bills, it was an extremely important part of the development of a brand-new concept.

Mr. Cordiano: I have had several constituents ask me why the extraction of wisdom teeth is an uninsured service, particularly when there is surgery involved.

Hon. Mr. Elston: There are two things. First of all, it is an uninsured service only in the case where there are no medical complications. It can still be covered fully as an insured service without any extra charges either for anaesthetic or for the dental surgery component, if there is a medical necessity determined by the attending dentist. For instance, if a person with an impacted wisdom tooth is a sufferer of a respiratory problem that would cause medical complications when anaesthetic is delivered for the purpose of the surgery, that could be done in a hospital as a fully insured benefit without any question whatsoever.

The reason that impacted wisdom teeth were taken in a general sense from the schedule of benefits was that the Ontario Dental Association made very strong representations on behalf of its membership to indicate that the extraction of impacted alveolars was not a medically necessary piece of surgery, that it could be done without medical complication and that it could be done in the office. We did not bend to their request that we take the entire procedure out.

I fought very long with them over some extended discussions to ensure that at least the medical component was retained because I could not see us putting anyone at risk. In fact, that was the real problem I felt we could not get around, which is why those are retained as benefits. That is the rationale upon which the decision was made.

Mr. Cordiano: Consequently, if a surgical procedure is required, it will have to be administered in a hospital?

Hon. Mr. Elston: If it is medically necessary. You would then have access to the anaesthetist who is delivering service in that hospital at the insured rate without extra billing charges. If someone goes into a hospital facility merely for the convenience of it, that is, the dentist feels it is a better place than his office, or his office does not have the same facilities, but it is not a medically necessary activity—in other words, there are no medical complications—it is not an insured service.

Mr. Cordiano: Even when an anaesthetic has to be administered?

Hon. Mr. Elston: That is correct. There must be a medically necessary component. In other words, there must be some complication, whether it be a problem with the respiratory system, blood pressure, age, etc. It may be a situation

where the person requires special medical attention to deliver the service; and in that case, permission can be received from OHIP to deliver that as a fully insured, medically necessary procedure without extra billing.

The Vice-Chairman: I presume members of the committee would like to proceed with the votes.

Votes 3101 through 3106, inclusive, agreed to.

The Vice-Chairman: This completes consideration of the estimates of the Ministry of Health.

Hon. Mr. Elston: The member did not move his amendment, which was to increase the minister's salary by 150 per cent.

The Vice-Chairman: Son of a gun, it is too late.

Hon. Mr. Elston: Missed again.

The Vice-Chairman: I thank the minister, the deputy minister and the staff for appearing and for their full answers. I am sure the critics will want me to extend those courtesies. You can pass them on to all and sundry.

The committee adjourned at 5:57 p.m.

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